

LEISURE CONNECTIONS: A CASE STUDY TO UNDERSTAND
FACILITATION TECHNIQUES WITH SURVIVORS OF TRAUMA

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Abstract

Leisure-based therapy is a potentially effective approach to supporting survivors of trauma in their healing. The purpose of this qualitative case study was to describe the recreation therapist's facilitation techniques of Leisure Connections, a unique leisure-based psycho-educational group for survivors of trauma, and explore how the facilitation was experienced by participants. Qualitative case study design, following the methods of Yin (1994) was used. One two week, three session Leisure Connections group was observed. Six participants completed the Group Therapy Alliance Scale (Pinsof & Catherall, 1986) and reflection cards. In-depth, semi-structured interviews were conducted with the recreation therapist and four participants. Six themes emerged describing group leader interventions, recreation therapist's actions, recreation therapist's preparation and reflections, group members' experience of a therapeutic alliance, group cohesion, and prior influences and assumptions. Therapeutic alliance and group cohesion were influenced by the recreation therapist's group leader interventions (drawing out, processing, protecting) and actions. The context of the group within a therapeutic community milieu was an important influence.

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Chapter One: Introduction

The purpose of this qualitative case study was to describe the Recreation Therapist's facilitation techniques of Leisure Connections (LC), a leisure-based psycho-educational group, and explore how this facilitation is experienced by participants. Leisure Connections is offered within the *Program for Traumatic Stress Recovery (PTSR)*; a program for survivors of trauma described by Wright & Woo (2000) as "a specialized, inpatient treatment program for adults suffering from post-traumatic stress disorder (PTSD)" (p. 105). This treatment program is accessible to individuals who have private health insurance or other financial resources.

This study adopted Haskell's (2003) definition of trauma as "an event that continues to exert negative effects on thinking (cognition), feeling (affect) and behaviour, long after the event is in the past" (p. 113). A traumatic experience is described in subjective terms, and as is defined as an individual's response to a perceived stressor involving "intense fear, helplessness, or horror" (Breslau, 2002, p. 924). The experience of psychological trauma may include: physical assault including rape, incest, domestic abuse, violent attacks, combat-related issues, work or automobile accidents, and natural disasters (Haskell, 2003; National Center for Posttraumatic Stress Disorder (NCPTSD), 2006; Veterans Affairs Canada, 2001). According to Schachter, Radomsky, Stalker, & Teram (2004), in Canada, prevalence rates for child sexual abuse range from 11.1 to 22% for women and 3.9 to 10% for men. The literature also indicates that measures of childhood trauma and sexual abuse are underreported due to the sensitive nature of disclosing traumatic experiences (Grella, Stein, & Greenwell, 2005; International Society

for Traumatic Stress Studies (ISTSS), 2007). Therefore, the actual rate of trauma prevalence may be higher than the 9% to 11% found in surveys (ISTSS).

There is a growing body of literature that reports the long-term effects experienced by adult survivors of childhood trauma (Bloom, 1994; Haskell, 2003; Rivera 1996). A report by the International Society for Traumatic Stress Studies (ISTSS), (2007) indicated that as a consequence of trauma “children are two to five times more likely to experience a mental illness as an adult” (p. 3). Research indicates an association between childhood traumatic events and later life psychological problems; including increased risk for depression, substance abuse, feelings of isolation, and development of posttraumatic stress disorder (Breslau, 2002; Grella et al., 2005; Herman, 1992; Jacobson & Herald 1990).

Posttraumatic stress disorder (PTSD) is defined by the presence of “a cluster of symptoms from exposure to a traumatic stressor” and results in “long-standing psychological, social, and biological sequelae” (Korn, 2001, p. 1). There are four criterion symptoms associated with posttraumatic stress disorder: persistent reexperiencing, avoidance, numbing, and hyper arousal (Taylor et al., 2003). The statistics, according to Cloitre, Cohen, Koenen, & Han (2002), indicate that posttraumatic stress disorder “has an estimated lifetime prevalence of between 5% and 10% in the general population” (p. 1067). There is a range of symptoms associated with posttraumatic stress disorder. Individuals often enter treatment years after a trauma has occurred. Individuals experiencing symptoms of posttraumatic stress disorder are difficult to treat and “therefore have the potential to absorb a greater percentage of health care costs in terms of support services, disability payments, and hospital costs” (Lubin, Loris,

Burt, & Johnson, 1998, p. 1173). The lifelong recovery process and challenges to effective treatment may indicate that the consequences of trauma constitute a significant cost to society.

The literature indicates that recovery from trauma may be a lifelong process, and “survivors may temporarily need safe retreats within which important therapeutic goals can be formulated and treatment can be organized” (Bloom, 1994, p. 476). Choate & Henson (2003) suggest that the process of recovery for adult survivors occurs when cognitive distortions are identified, emotions related to the abuse are processed, and an understanding of how the past affects present-day functioning is reached. According to Herman (1992) the type of therapy settings for survivors of trauma is described as a continuum of care that may include out-patient, in-patient, as well as individual and group treatment; and consists of three stages: safety, remembrance and mourning, and reconnection.

The literature reveals a range of treatment options for survivors of trauma. Group intervention approaches currently used to treat posttraumatic stress disorder include: supportive, psychodynamic, and cognitive-behavioral (CBT) approaches (Foy, Eriksson, & Trice, 2001; Foy et al., 2001; Scurfield, 1985). The *Program for Traumatic Stress Recovery (PTSR)* uses a cognitive-behavioural treatment approach and an adaptation of Bloom’s Sanctuary Model (1994). It is a voluntary inpatient treatment program “that was developed to treat the under recognized symptoms of chronic posttraumatic stress disorder” (Wright & Woo, 2000, p. 105). Patients enter the program with different trauma histories; different experiences of trauma; and in different stages of recovery from trauma. A multidisciplinary team delivers specialized treatment for all types of trauma.

Program elements are offered primarily in group format. The program is described in Chapter Three.

Leisure Connections is described as a leisure-based psycho-educational group offered within the *Program for Traumatic Stress Recovery (PTSR)*. Leisure Connections is offered as an elective group to patients through self-selection or by referral from program team members. The group, Leisure Connections (LC) incorporates psycho-education, cognitive-behavioural therapy, and “psychotherapy processing” (Griffin & Arai, 2008, p. 35). According to Gass (1993), experiential learning is defined as a process of “learning by doing combined with reflection” (p. 4). In addition, a key component of experiential learning is that behaviour change or learning occurs while a participant is involved in the experience of activities that create challenge, discomfort, and a need to problem-solve (Gass, 1993). The focus is that the participant is placed in a learning situation [Leisure Connections] that is active versus passive. It is a closed group format; no additional group members can participate after the start of the first session. A maximum of eight participants are involved in one four-session block, which occurs over a two-week span. For the purpose of the current study, due to a statutory holiday, three sessions of LC occurred instead of four. Each session is seventy minutes in duration, and is facilitated by a Recreation Therapist (RT). Leisure Connections group focuses on healthy leisure choices, lifestyle balance, traumatic reenactment in leisure, and the reconnection to leisure (Griffin, 2005).

Statement of the Problem

Two main problems underlie the need for this study; both stemming from the lack of literature on this topic. First, there is a need to understand and document how Leisure

Connections is facilitated to deepen the Recreation Therapist's ongoing reflective practice and to enable other members of the multidisciplinary team to be able to facilitate the group if necessary (i.e., due to the RT's departure or absence). The Recreation Therapist facilitating Leisure Connections describes reflective practice as an essential part of her approach to facilitation (Griffin, 2005). This research study has been requested by the Recreation Therapist to explore her practice in greater depth. As Griffin (2005) describes, to be effective and professional as a facilitator, "it is important for me to reflect after each group on what my experience was, to be aware of how my own issues were triggered and/or how I responded to a certain dynamic or patient" (p. 224). Consequently, should the RT leave the program or be absent for a period of time, other members of the multidisciplinary team have no accessible documentation or training manual to facilitate LC. The complex ways in which the therapeutic modalities of psycho-education, cognitive-behavioural therapy, experiential exercises and psychotherapy processing are connected in the facilitation of LC is both neither fully understood nor documented. The specific therapeutic techniques used by the RT to facilitate Leisure Connections are not documented.

Second, there is a lack of literature that describes how facilitation with survivors of trauma is experienced. Studies supporting leisure as an effective therapeutic intervention for adult survivors of trauma who experience posttraumatic stress symptoms are limited (Griffin, 2005; Meister & Pedlar, 1992). What does exist is a focus on leisure as coping with negative life events, including chronic illness or a traumatic injury (Hutchinson, Loy, Kleiber, & Dattilo, 2003; Kleiber, Hutchinson, & Williams, 2002); and

literature which examines leisure involving experiential activities and adventure therapy groups for high-risk populations (Gass, 1993; Kelly, 2006; Russell, 2004).

Purpose of the Study

The purpose of this qualitative case study was to describe the facilitation techniques used by the Recreation Therapist and explore how this facilitation is experienced by participants. A qualitative case study approach will provide the opportunity to describe what the Recreation Therapist “does” to facilitate Leisure Connections. One block of Leisure Connections group is the selected case.

This qualitative case study will address the following research questions:

1. What does the Recreation Therapist (RT) do to facilitate Leisure Connections?
2. How is the facilitation experienced by group members?

The primary research question for this study is “What does the Recreation Therapist do to facilitate Leisure Connections?” This question assumes that what the Recreation Therapist “does” includes utilizing a range of therapeutic techniques; group facilitation techniques and strategies in response to the perceived needs, readiness and processes of the group. Facilitation involves more than the physical actions of leading a group. To better understand the facilitation techniques used in the group, a second, subsidiary question is posed: “How is the Recreation Therapist’s facilitation experienced by group members?”

Summary

This chapter introduced Leisure Connections, a group offered as a treatment option within the *Program for Traumatic Stress Recovery (PTSR)*; a specialized program

for survivors of trauma. The Recreation Therapist uses psycho-education, cognitive-behavioural therapy, experiential exercises and psychotherapy processing in the group. The following chapter builds a foundation for understanding stress, trauma and health among an inpatient population of survivors of trauma. Included is: literature on stress, trauma, and health; trauma and posttraumatic stress disorder; leisure and health; leisure education and cognitive-behavioral therapy; introduction of the concept of a therapeutic community; and group therapy processes. Chapter Three introduces the research questions, conceptual framework, and propositions. Chapter Four describes the methodology used throughout the research process. Chapter Five presents the findings from all data sources; the interviews with participants and Recreation Therapist; direct observations of Leisure Connections; Reflection Card documents; and participant responses to the Group Therapy Alliance Scale. Chapter Six presents a revised conceptual framework and concludes with a discussion of the strengths and weaknesses of the current study and provides suggestions for future research.

Chapter Two: Review of Literature

The aim of this study is to describe the Recreation Therapist's facilitation techniques used in Leisure Connections group, and explore how the facilitation is experienced by participants. A review of the literature was conducted at three points during this study: prior to the start of the study (February 2007), during the data analysis and interpretation phase (April 2009), and again during the writing phase (August 2009). The researcher conducted an initial literature search to get an understanding of the studies that had already been done in relation to the current area of study.

In February 2007, a search for relevant peer-reviewed journals was conducted using CINAHL and Scholarsportal with the filters for the period after 2000 and before 2008. The search strategy using keywords, 'recreation therapy and trauma survivors' yielded 0 citations. Using the keywords, 'psychotherapy and PTSD' also yielded 0 citations. The use of keywords 'group therapy and trauma' yielded 11 hits; all of which were textbook sources.

In April 2009, a search of the Cochrane Review using the search term 'PTSD' yielded 5 methods studies, 572 clinical trials, and 564,387 general articles on PTSD. A search using CINAHL with the search term 'recreation therapy and PTSD' yielded 86,745 results. To narrow the search, the major heading 'psychotherapy' was used and yielded 460 results. Using the major heading, 'survivors' yielded 3 results. The focus of these studies was on Holocaust survivors, earthquake survivors and the Veteran population. A quantitative approach was used in these studies. Criteria for review included qualitative studies that occurred after 2007.

In August 2009, a search of the PILOTS (Published International Literature of Traumatic Stress) database from 2007 forward yielded the following results: using the search terms ‘group therapy and trauma survivors’ (3 results), ‘recreation therapy and trauma survivors’ (0 results); ‘milieu therapy and trauma survivors’ (1 result), ‘therapeutic recreation and survivors of trauma’ (0 results), ‘healing and therapeutic recreation’ (1 result); ‘group psychotherapy and therapeutic recreation’ (1 result); ‘experiential therapy and trauma’ (1 result); ‘recreation therapy and PTSD’ (2 results); ‘psychotherapeutic group processes and PTSD’ (0 results). In total, 8 studies that were relevant to the current study were retrieved (some were repeated in the different search terms used); the only study relevant to therapeutic recreation and trauma was Arai, Griffin, Miatello, and Greig (2008). A search using the Cochrane Review using the search term ‘group therapy and trauma’ yielded 1 quantitative review of a randomized control trial.

In August 2009, a search using CINAHL with limiters ‘published date from January 2007 to April 2009’ (peer-reviewed journals) with search terms ‘group therapy and PTSD’ yielded 26 results. Five of the studies were systematic reviews. To narrow the search major subjects ‘survivors’ and ‘psychotherapy’ were added to yield 3 results; one relevant to this study, (Robertson, Rushton, Batrim, Moore & Morris, 2007). Criteria for review included qualitative studies that occurred after 2007.

The literature in this review is divided into five sections. First, to understand the inpatient population of the Program for Traumatic Stress Recovery, the literature will review concepts of stress and trauma and the relationship to health; and trauma in relation to the anxiety disorder referred to as posttraumatic stress disorder (PTSD) (American

Psychiatric Association [APA], 1994; Cloitre, Cohen, Koenen, & Han, 2002; Haskell, 2003; National Center for Posttraumatic Stress Disorder (NCPTSD), 2006; Veterans Affairs Canada, 2001). Second, the concepts of leisure and health (Caldwell, 2005; Hutchinson & Kleiber, 2005; Shank & Coyle, 2002); leisure and PTSD (Meister & Pedlar, 1992); and leisure and traumatic reenactment (Griffin, 2005) will be explored. Third, this review of literature introduces the group, Leisure Connections, and describes the Leisure Ability Model (Stumbo & Peterson, 1998) which provided the original therapeutic recreation model for Leisure Connections. Fourth, to understand the merging philosophies of the *Program for Traumatic Stress and Recovery*, literature from the therapeutic community milieu (Filstead & Rossi, 1973) and the Sanctuary/S.A.G.E. treatment model (Bloom, 1994) are introduced. Fifth, to gain an understanding of the facilitation techniques used by the Recreation Therapist, the review of literature introduces group theory and processes as a framework for understanding the evolution of Leisure Connections group from a psycho-educational format; one that incorporates the use of experiential exercises for processing issues of trauma (Gass, 1993; Griffin, 2005; Shank & Coyle, 2002). Each of these sections will provide a general description of the concepts and link their utility to Leisure Connections.

Stress, Trauma and Health

The link between stress and chronic stress, associated with a posttraumatic stress response, is connected to health. In this study, stress is defined as, “a relationship between the individual and the environment that is appraised by the individual as taxing or exceeding his/her resources and endangering his/her well-being” (Lazarus & Folkman, 1984, p. 19). This definition suggests that stress is an interactive and a cognitive process

that occurs between self and the environment. According to the Santa Barbara Graduate Institute Center for Clinical Studies (2006), the experience of a “normal” stress response returns the nervous system to equilibrium following a stressful event. However, an individual who appraises a stressful event as traumatic may experience an interruption in “relationships and overall functioning” (p. 2). They state that “trauma is stress run amuck” (p. 2).

The literature on stress indicates that over time, an accumulation of stressful life events and an individual’s inability to cope are associated with negative health consequences. Further, research supports that stressful life events do impact physical and psychological health and “they have been shown to influence the risk for, the initiation of, and the course of a wide range of physical and emotional disorders from colds and infections . . . and posttraumatic stress disorder” (Werner & Frost, 2000, p. 101). Lyon (2000) describes that “[t]he experience of stress, particularly chronic stress, takes a significant toll on the well-being of individuals in terms of emotional and physical discomforts as well as functional ability” (p. 4).

Health is defined by the World Health Organization (WHO) as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity” (World Health Organization, 1948; 2007). Both the *Program for Traumatic Stress Recovery* and Leisure Connections identify with this definition, which encompasses a holistic understanding of health. The program philosophy and treatment approach incorporates the social, emotional, physical, environmental and spiritual aspects of healing for survivors of trauma (Homewood Health Centre, 2006). As described by

Griffin (2005), in *Leisure Connections* “experiential exercises are a full body experience: physically, mentally, emotionally, socially, and spiritually” (p. 214).

Trauma and Posttraumatic Stress Disorder

The definition of trauma used in this study is adopted by Haskell (2003), who refers to a traumatic experience as “an event that continues to exert negative effects on thinking (cognition), feeling (affect) and behaviour, long after the event is in the past” (p. 113). As described by the Centre for Addiction and Mental Health, trauma is the emotional response to a physical, sexual or emotional assault (Centre for Addiction and Mental Health [CAMH], 2006). In Canada, prevalence rates for child sexual abuse range from 11.1 to 22% for women and 3.9 to 10% for men (Schachter, Radomsky, Stalker, & Teram, 2004). In addition, other factors may contribute to trauma including combat related stress, abuse and rape in adulthood, witnessing violence, work related injury, natural disasters. As indicated by Breslau (2002), some individuals are at risk of developing PTSD following a traumatic event however; “epidemiologic studies consistently reported that only a small subset of trauma victims succumbs to posttraumatic stress disorder [PTSD]; most do not” (p. 928). The distinguishing factor, which contributes to the development of posttraumatic stress disorder, is that an individual will “become stuck on the trauma; they keep reliving it in thoughts, feelings, actions or images” (van der Kolk, McFarlane, & van der Hart, 1996, p. 419). The Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV, 1994) reports the lifetime prevalence for Posttraumatic Stress Disorder in community-based studies “ranging from 1 to 14%” (p. 426).

According to the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders, 4th Edition (DSM-IV, 1994), posttraumatic stress disorder is a condition related to the development of characteristic symptoms after direct exposure or witnessing of an "extreme stressor" (p. 424). Posttraumatic stress disorder involves response to an extreme stressor involving a sense of helplessness, horror, and intense fear (APA, 1994). Signs of posttraumatic stress disorder include flashbacks or "re-experiencing the traumatic event(s); persistent symptoms of increased arousal; continued avoidance of stimuli associated with the trauma and numbing of general responsiveness" (APA, 1994, p. 424). Individuals who experience frequent or prolonged exposure to a stressor may have an increased risk for developing Posttraumatic Stress Disorder (PTSD). Secondary symptoms associated with the disorder may include: depression, hopelessness, aggressive behaviour, guilt and shame, and social isolation (NCPTSD, 2006).

Wright & Woo (2000) reported that 95% of the *Program for Traumatic Stress Recovery (PTSR)* participants fulfilled the criteria for PTSD; with 33% receiving the diagnosis prior to admission. Often, individuals who experience symptoms of posttraumatic stress disorder exhibit a compromised ability to function in relational, psychological, emotional, social and occupational realms. These symptoms indicate a coping style that, over time, becomes strategies that are maladaptive, restrictive and potentially self-harming (Bloom, 1994; Herman, 1992). Breslau (2002) identified three risk factors for PTSD following a traumatic event that are "reported consistently across studies: psychiatric history, history of childhood trauma, and family history of psychiatric disorders" (p. 926).

Leisure, Health and Trauma

This section provides a review of literature on leisure in relation to: health, trauma, and PTSD. According to Dattilo (2000), leisure is defined as a “subjective state of mind when individuals experience a sense of freedom and are motivated to participate in an activity” (p. 167). This statement is consistent with other literature, which suggests that defining an experience of leisure involves a subjective and internal perspective. Leisure is characterized as specific types of activity; as free time from obligations; as meaningful and satisfying experience; or as some combination of activity, time, and experience (Mannell & Kleiber, 1997). Leisure Connections group adopts a broad definition of leisure to explore the role of leisure, and the concept of healthy leisure experiences as a resource for self-nurturing, and healthy coping (Griffin, 2005).

The link between leisure and health is described in the literature, stating that involvement in leisure activity may contribute to improved physical, social, emotional and cognitive dimensions of health (Austin, 2001; Caldwell, 2005; Hutchinson & Kleiber, 2005; Meister & Pedlar, 1992). Hutchinson & Kleiber (2005) argue that one contribution of leisure to health includes a restorative role; that leisure has the potential to foster a sense of relaxation, emotional well-being and comfort in people’s lives. According to Caldwell (2005) the understanding of leisure as therapeutic is described by three existing areas of research on leisure and health; “prevention of, coping with, and transcending negative life events” (p. 8).

Given the influences leisure may have on health it stands as an important counter measure to the negative impacts that trauma has on health. As Meister & Pedlar (1992) report “trauma may manifest itself . . . in all aspects of one’s life—mental, physical, and

emotional” (p. 24). The authors explored the role of leisure and social support networks of female childhood survivors of sexual abuse, in an inpatient treatment group setting. A key finding in the study suggests that “survivors were unable to experience the benefits of those leisure pursuits which involved social interaction” (Meister & Pedlar, 1992, p. 55).

Not only does trauma have an influence on leisure, as described by Meister and Pedlar (1992), Griffin has also found that individuals who have experienced trauma may also use leisure time and pursuits to reenact trauma. Traumatic reenactment is described as re-creation of a traumatic experience through thoughts, feelings, and/or behaviors. Through non-verbal behaviors survivors of trauma may “reenact what they can’t remember” (Bloom, 1999, p. 10). According to Griffin (2005), through their choices of leisure activities, survivors of trauma may be sustaining unhealthy coping strategies and beliefs. Leisure activities may enable avoidance behaviours commonly associated with a posttraumatic stress response. Griffin (2005) identified four such behaviours: isolation in leisure, avoidance of leisure activities, busy leisure lifestyle, and self-harm in leisure. This statement supports the need for therapeutic group interventions focused on leisure with survivors of trauma.

Leisure Connections, Therapeutic Recreation and the Therapeutic Community

This section introduces the group, Leisure Connections, and describes therapeutic recreation and the Leisure Ability Model (Stumbo & Peterson, 1998) which provided the original therapeutic recreation model for Leisure Connections. Leisure Connections is based upon a foundation of therapeutic recreation which differs from recreation services (Searle & Brayley, 1999). Therapeutic recreation is defined as, “a purposeful intervention directed at the individual and his environment that aims to enhance health and impact

functioning in many critical life domains” (Searle & Brayley, p. 162). According to Shank & Coyle (2002), therapeutic recreation involves a systematic and planned use of recreation and other activities as interventions. The authors outline that therapeutic recreation includes a helping and supportive relationship that will effect change in a client’s attitudes, beliefs, behaviors and skills necessary for psychosocial adaptation, health and well-being.

The Leisure Ability Model as the Foundation of Leisure Connections

Central to the development of therapeutic recreation since the 1980s has been the Leisure Ability Model. The premise of the model is that individuals who receive therapeutic recreation services will have the opportunity to experience a “leisure lifestyle” (p. 83). This model is a practice model that describes three service components: treatment, leisure education, and recreation participation (Peterson & Gunn, 1984; Stumbo & Peterson, 1998). Each of the three service components has specific purposes, and the “overall anticipated outcome of therapeutic recreation service delivery is a satisfying leisure lifestyle” (Stumbo & Peterson, p. 87). Leisure Connections incorporates all three service components. The treatment area of this practice model focuses on addressing client deficits and improving functional ability in four areas: (1) physical, (2) mental, (3) emotional/affective, and (4) social. Leisure Connections also incorporates a focus on Leisure Education to assist participants in developing self-awareness and resources for healthy leisure choices (Griffin, 2005). As Stumbo and Peterson describe leisure education focuses on assisting clients to acquire leisure-related attitudes, knowledge, and skills including: a) awareness of leisure and its benefits to individual health, b) social interaction skills for participation in leisure, c) leisure activity skills, and

d) knowledge of leisure resources. Leisure Connections also emphasizes independent recreation participation – the purpose of this component is to introduce new leisure activities and experiences that “allow the client greater freedom of choice” (Stumbo & Peterson, p. 91).

Leisure Connections

Leisure Connections (LC) is offered as an elective group within the *Program for Traumatic Stress Recovery (PTSR)*. The Recreation Therapist who facilitates the group, is a graduate of the Therapeutic Recreation option at the University of Waterloo, and has over ten years experience facilitating Leisure Connections with adult survivors of trauma.

Leisure Connections is a psycho-educational group that focuses on healthy leisure choices, promoting a balanced lifestyle, traumatic reenactment in leisure, and re-connection to leisure. Leisure Connections is a closed group with a maximum of eight patients per four-session block. Participation is made by referral from the treatment team or by the patients themselves. Leisure Connections meets two times per week, for two weeks.

The initial purpose of Leisure Connections is described by Griffin (2005) as a “discussion-based education group that utilized some paper and pencil exercises” (p. 213). This approach led to the development of learning modules that addressed: leisure attitudes, leisure values/benefits, leisure motivations, and leisure barriers/resources. Discussion and sharing in group explored how survivors of trauma respond to free time, and introduced leisure as a healthy coping resource. Leisure Connections has continued to evolve over time. The Recreation Therapist has incorporated an eclectic approach to group, including the use of experiential exercises and psychotherapy processing. Specific

therapeutic techniques used by the Recreation Therapist to facilitate Leisure Connections are unknown. Documentation describing the facilitation techniques are intended to be used in the development of a program manual and contribute toward the larger research project; a program evaluation.

Therapeutic Community

Understanding Leisure Connections also requires an understanding of the *Program for Traumatic Stress Recovery (PTSR)* and its underlying philosophy of a therapeutic community. The term therapeutic community originated from the work of Thomas Main, a British doctor, who viewed the hospital as a social community available for treatment of soldiers returning from World War II. The ‘moral treatment’ philosophy informed the concept of a therapeutic community. According to Filstead & Rossi (1973) this philosophy “emphasized the necessity of treating the mentally ill as human beings and developing the full capacity of individuals by making use of their social setting” (1973, p. 5). According to Bloom (1997) with the development of the therapeutic community milieu came the widespread use of early forms of group therapies. In the Program for Traumatic Stress Recovery, a therapeutic community allows for healing to occur within the environment of a community milieu (Wright & Woo, 2000). Together, the staff and patients of the *Program for Traumatic Stress Recovery* provide the larger therapeutic community and the social context “to rehearse healthy behaviours” (Griffin, 2005, p. 208). A significant part of the program is delivered in group format. The program structure of the community milieu encourages activities that focus on: physical safety, emotional safety, environmental safety, social safety and spiritual safety. The PTSR is described as being adapted from Bloom’s Sanctuary Model which was

created as an “elaboration of the therapeutic milieu concept” (Bloom, 1994, p. 476).

Treatment is described as incorporating the use of the acronym S.A.G.E. (safety, affect management, grieving, and emancipation) as a treatment philosophy (Bloom, 1994; Wright & Woo, 2000).

Group Theory

There is limited research supporting the use of leisure-based psycho-educational groups with inpatient survivors of trauma (Griffin, 2005). Understanding group processes within Leisure Connections requires an understanding of the following: therapeutic alliance, group cohesion, cognitive-behavioural therapy, psycho-education, experiential exercises, group processing and group leadership. Each of these is described further in the following sections.

Therapeutic Alliance

Recent literature on survivors of trauma outlines the importance of creating a safe and trusting therapeutic environment (Haskell, 2003; Rivera, 1996; Stalker, Palmer, Wright & Gebotys, 2005). In this study, therapeutic alliance is defined as the relationship between a therapist [Recreation Therapist] and the client [Leisure Connections participant] that is collaborative, and respectful in nature. It is regarded as the most fundamental component and seen as the foundation of the therapeutic process (Haskell, 2003; Rivera, 1996). Some of the key elements that characterize a therapeutic alliance are described as: collaborative and mutual engagement, validation and empathic attunement, and empowering clients to make change (Haskell, 2003; Rivera, 1996). In the process of a therapeutic relationship an emotional investment is entered into by both the facilitator

and client. This interpersonal connection forms a therapeutic alliance that is structured within the facilitator/client dyad (Corey, 1996; Rivera, 1996).

Survivors of trauma often struggle with issues of trust and interpersonal safety. Challenges in developing therapeutic relationships may disrupt the “basic human capacities of trust, autonomy, initiative, competence, identity, and intimacy” (Wright, Woo, Muller, Fernandes, & Kraftcheck, 2003, p. 395). As suggested by some authors, trust and safety are integral in establishing a therapeutic alliance, and a key factor in enhanced treatment outcomes (Haskell, 2003; Herman, 1992; Pearlman & Courtois, 2005; Rivera, 1996).

Griffin (2005) supports the concepts of trust and safety by introducing the following elements of safety in the *Program for Traumatic Stress Recovery (PTSR)*: physical, emotional, environmental, social, and spiritual. Creating safety will increase the opportunities for establishing a collaborative relationship between the practitioner and client. Safety is integral in the development of a therapeutic alliance (Haskell, 2003; Rivera, 1996).

Group Cohesion

Some literature suggests that a shared history of trauma provides group members with a sense of connectedness and group cohesion (Bloom, 1997; Herman, 1992; Yalom & Leszcz, 2005). This study uses the broad definition of group cohesion as “the result of all the forces acting on all the members such that they remain in the group, or more simply, the attractiveness of a group for its members” (Yalom & Leszcz, 2005, p. 55). As stated by Yalom & Leszcz members of a cohesive group, “feel warmth and comfort in the group and a sense of belongingness; they value the group and feel valued, accepted and

supported by others (p. 55). The concept of group cohesion can be explained as the sense of group alliance/cohesion; both among members and with the group leader. Group cohesion is linked to the effectiveness of group therapy (Marziali, Munroe-Blum, & McCleary, 1997; Yalom & Leszcz, 2005).

Cognitive-Behavioural Therapy

The *Program for Traumatic Stress Recovery* incorporates cognitive-behavioural therapy (CBT) in a group format. Program components are delivered “almost exclusively by means of a group modality” (Wright & Woo, 2000, p. 110). In *Leisure Connections*, the Recreation Therapist describes her approach as eclectic; drawing on her knowledge of cognitive behavioural therapy techniques (Griffin, 2005).

For the purpose of this study, cognitive-behavioural therapy (CBT) is defined as a skills-based treatment which focuses on identifying and making change to maladaptive patterns of thinking and behaving (National Association of Cognitive-Behavioral Therapy (NACBT), 2006; The Ottawa Anxiety and Trauma Clinic, 2006).

Cognitive-behavioural group treatment interventions—psycho-education, desensitization procedures such as stress inoculation training and/or imaginal exposure, and assertiveness training—have been the primary treatment approach for survivors of stress and trauma (Korn, 2001; Ottawa Anxiety and Trauma Clinic, 2006; Santa Barbara Graduate Institute for Clinical Studies and Research, 2006). The literature supports the use of cognitive-behavioural therapy as an effective treatment choice for survivors of trauma and PTSD symptoms (Korn, 2001; Scurfield, 1985). The *Oxford Handbook of Psychiatry* (2005) lists CBT as the “treatment of choice” for the management of posttraumatic stress disorder (Semple, Smyth, Burns, Darjee, & McIntosh, 2005, p. 370).

Psycho-education

Psycho-educational groups are structured around a relevant theme or topic, which is related to the well-being and health of group members (Shank & Coyle, 2002). In psycho-educational groups, information is presented with an opportunity to “examine underlying psychological issues that affect participants’ intentions to use the information” (p. 212). Psycho-educational groups incorporate education, skill enhancement, and social support in a structured format. Leisure Connections has evolved from a “structured four-session psycho-educational format of; leisure attitudes, leisure benefits, leisure motivations, and leisure barriers” to include the use of experiential exercises (Griffin, 2005, p. 212).

Experiential Exercises

In this study, experiential learning is defined as a process of “learning by doing combined with reflection” (p. 4). Experiential learning is a process that involves present, as well as future learning; conflict resolution, reflection, and behaviour change, which occur while a participant is involved in the experience of activities. The activities create challenge, discomfort, and a need to problem-solve (Gass, 1993).

With increased skill development and self-reflective practice from the RT, and feedback from group participants, over time, Leisure Connections has evolved to include an experiential component. As described by the RT, the group uses “in-the-moment” experiential exercises that include “a full body experience; physically, mentally, emotionally, socially, and spiritually” to process their insights and feelings related to the exercise (Griffin, 2005, p. 214).

The use of experiential exercises with survivors of trauma allows group members to process non-verbally, and challenges perceptions associated with their trauma history in a safe and supportive environment (Griffin, 2005; Webb, 1993). Leisure Connections provides a context to challenge existing thoughts and rehearse new behaviours.

Group Processing

Concepts related to group processing, group process, and group leader interventions are introduced. According to the Best Practice Guidelines of the *Association for Specialists in Group Work (ASGW)*, group processing is explained as “assessing progress on group and member goals; leader behaviors and techniques, group dynamics and interventions; developing understanding and acceptance of meaning” (Association for Specialists in Group Work as cited in DeLucia-Waak & Kalodner, 2005, p. 79). The three critical elements of group processing are: “good questioning skills, accurate empathy, and awareness of the focus of the group” (p. 79). The focus will differ according to the leadership and membership at a given point in time. The term, group process, is defined by Stockton, Morran, & Nitza (2000) as the “dynamics that naturally occur in a group or the nature of the relationship between interacting individuals” (p. 345). According to the authors, the terms are related; processing, as an intervention, helps group members make meaning of the group process.

As described by Shank & Coyle (2002, p. 291) in therapeutic recreation groups “processing is a therapeutic technique” and specifically, processing:

- assists clients in making connections between thoughts, feelings, and behavior
- consolidates learning from activities
- promotes group cohesion

- presents opportunities to receive feedback from others, as well as the chance to learn from others

Therefore, processing, within therapeutic recreation, is a therapeutic technique that focuses on the here and now behaviors evident in activities. According to the authors, processing also helps clients “to generalize from the present activity to life beyond the intervention” (p. 219).

Group Leadership

Morran, Stockton, & Whittingham (2004) conducted an extensive review of the research and practice literature, and produced an inventory of 10 group leader interventions with clear descriptions. The group leader interventions [facilitation techniques] are supported for use in both psycho-educational and group therapies. For this study, the researcher used the 10 group leader interventions [facilitation techniques] as a guide during the direct observations and analysis. This created a systematic way to connect the techniques; what facilitation techniques were utilized, and how participants interacted with the group leader during analysis.

The 10 group leader interventions are grouped into two categories; protecting group members/promoting safety, and energizing/involving group members. Protecting group members/promoting safety involves: (1) protecting, (2) blocking, and (3) supporting. Energizing/involving group members involves: (4) drawing out, (5) modeling, (6) linking, (7) processing, (8) interpreting, (9) self-disclosing, and (10) feedback (see Appendix G).

Summary

Chapter Two provides information relevant to this case study of Leisure Connections. The chapter began with a description of stress, trauma and posttraumatic stress disorder (PTSD). Then, the concepts of leisure in relation to health and trauma were discussed and the roots of Leisure Connections in therapeutic recreation and the Leisure Ability Model (Stumbo & Peterson, 1998) described. Providing a context for understanding Leisure Connections, the Program for Traumatic Stress and Recovery was discussed in relation to the therapeutic community milieu and Bloom's Sanctuary Model (1994). As a foundation for understanding the facilitation techniques used by the Recreation Therapist, this chapter concluded with a review of literature on therapeutic alliance, group cohesion, cognitive-behavioural therapy, psycho-education, experiential exercises, group processing and group leadership.

Chapter Three: Research Questions, Conceptual Framework, and Propositions

The purpose of this case study was to describe the facilitation techniques used by the Recreation Therapist and explore how this facilitation was experienced by participants. A qualitative case study approach was selected to provide the opportunity to describe what the Recreation Therapist “does” to facilitate Leisure Connections. The following research questions were posed:

1. What does the Recreation Therapist (RT) do to facilitate Leisure Connections?
2. How is the facilitation experienced by group members?

Conceptual Framework

A conceptual framework is not included as one of the five necessary components of a case study research design (Yin, 2003). However, according to Miles & Huberman (1994) a conceptual framework explains the main dimensions of a study - “the key factors, constructs, or variables - and the presumed relationships among them” (p. 18). Further, the “focusing and bounding function of a conceptual framework” assists the researcher in determining what will and what will not be studied (p. 19). The initial conceptual framework (Figure 1) was developed prior to the current study, and was used to guide data collection and analysis. This process is consistent with Miles & Huberman (1994) who suggest that the conceptual framework is developed before research begins. The initial conceptual framework is consistent with findings of the larger research project and was developed from: what this researcher learned during discussions with the Recreation Therapist; attending practice observations; how the researcher’s understanding of Leisure Connections group was situated within the larger therapeutic community (PTSR) program and; the literature about group psychotherapy.

The dotted circles in the conceptual framework represent the main dimensions of the propositions, or the “key factors” that are described by the researcher. The presumed interrelationships in the study are indicated by the use of two-way arrows. The use of dotted circles represents the overlap and presumed relationship between key components in this study. The dotted circles denote the indeterminable boundary existing between the propositions.

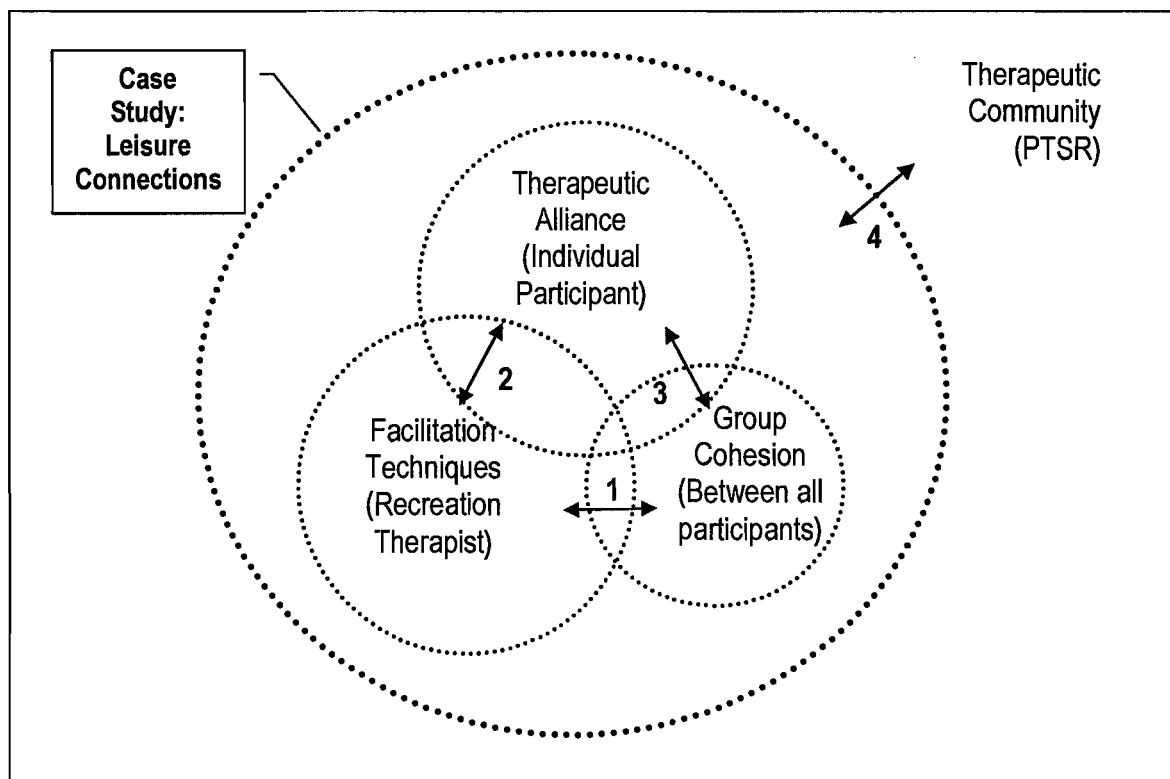


Figure 1. Initial conceptual framework.

Components of the Conceptual Framework

Facilitation Techniques

The first component of the conceptual framework consists of the facilitation techniques used by the Recreation Therapist in Leisure Connections. The two-way arrows

indicate that during Leisure Connections, the Recreation Therapist will lead the group using facilitation techniques that may include a range of therapeutic factors (arrow 2); these factors will be experienced by the therapist and group participants in part, as influencing group cohesion (arrow 1).

Therapeutic Alliance

The second component, therapeutic alliance, is the relationship and therapeutic rapport between the Recreation Therapist and individual participants (arrow 2). The arrow (2) indicates the presumed mutual experience of a therapeutic alliance, which may be influenced by characteristics of the therapist's facilitation techniques. The perception of a therapeutic alliance impacts the participants' experience of group cohesion (arrow 3).

Group Cohesion

The third component, group cohesion, is related to participants' individual experience of a therapeutic alliance, and the relationship between all participants' perceived experience of group cohesion (arrow 3). Arrow 1 indicates the influence of the Recreation Therapist's facilitation techniques on the experience of group cohesion. Arrow 1 also indicates the presumed choice of facilitation techniques used by the Recreation Therapist, based on her perception of group cohesion.

Therapeutic Community (PTSR)

The fourth component, therapeutic community, represents the presumed influence of characteristics that exist within the larger PTSR community, the *Program for Traumatic Stress Recovery*. The therapeutic factors in community may influence participants' experience of Leisure Connections (arrow 4). These therapeutic factors may

include: clients in the program who do not participate in Leisure Connections, patients from other programs within the hospital, other groups attended in the PTSR program, and different treatment team members. Arrow 4 also indicates that the Leisure Connections experience may also have an influence on the larger therapeutic community.

Propositions

A proposition is one important component of a case study (Yin, 1994). As suggested by Yin, the generation of propositions “directs attention to something that should be examined within the scope of the study” (p. 21). Yin (2003) also noted that the development of study propositions directs the researcher toward relevant evidence. Propositions flow from the conceptual framework and assist in explaining the findings of the study (Miles & Huberman, 1994). In this study, four propositions were derived from the review of the literature, research study team meetings, a preliminary practice observation of Leisure Connections group, as well as this researcher’s clinical experience facilitating groups in various treatment settings. The four propositions in this study are:

1. The Recreation Therapist will facilitate Leisure Connections using a range of therapeutic techniques. How the Recreation Therapist facilitates Leisure Connections will contribute to the experience of a therapeutic alliance and impact group cohesion.
2. Individual group members may experience the presence of a therapeutic alliance between themselves and the Recreation Therapist. Their experience of a therapeutic alliance will be connected to experiencing characteristics such as: trust, safety, empowerment, and validation. This proposition presumes a collaborative experience between the Recreation Therapist and group members.

3. Group cohesion will be influenced by the presumed presence and experience of a therapeutic alliance, during the facilitation of Leisure Connections.
4. An assumption exists that the larger therapeutic community (PTSR) may impact and/or contribute to the participants' experience of a perceived therapeutic alliance and group cohesion in Leisure Connections. Although not a focus of this study, this proposition presumes an influence of characteristics such as: other PTSR program patients and staff, therapeutic factors related to other program components, and other hospital patients from different program areas, for example, the alcohol and drug program or the integrated mood and anxiety program.

Chapter Four: Methodology

The purpose of this case study was to describe the facilitation techniques used by the Recreation Therapist and explore how this facilitation was experienced by participants. A qualitative case study approach was used. As defined by Creswell (1994), a case study is one design “in which the researcher explores a single entity or phenomenon (“the case”) bounded by time and activity (a program, event, process, institution or social group) and collects detailed information by using a variety of data collection procedures” (p. 12).

Case

According to Miles & Huberman (1994) the case is the unit of analysis. For this study, the case was one two-week block of the group, Leisure Connections (LC). This study was designed using methods and procedures described by Yin (2003). The timeframe was limited to a two-week data collection period.

Case Study Protocol

Yin (2003) describes the complex process of doing data collection and suggests the development of a case study protocol in preparation for conducting research. A case study protocol includes the following sections: the case study project overview, case study questions, procedures in the field, and a guide for the case study report.

Case Study Project Overview

This case study was part of a larger qualitative research project conducted at Homewood Health Centre located in Guelph, Ontario. The purpose of the larger research

project was to conduct a program evaluation involving process and outcome evaluations of Leisure Connections (LC). Within this larger study, data were collected in three phases. In Phase I data were collected by Ashleigh Miatello, in Phase 2 Dr. Susan Arai collected the data, and in Phase III data were collected by this researcher, Carrie Greig. Each researcher observed the group Leisure Connections. Data from all three phases were used by Dr. Arai for the larger process and outcome evaluation of Leisure Connections. This current qualitative case study used data from Phase III to describe the facilitation techniques used by the Recreation Therapist in the leisure-based psycho-education group, Leisure Connections (LC) and the experience of the facilitation as described by the participants.

As Yin (1994) suggests, a case study approach addresses “how” or “why” questions (p. 5). Further, Yin (1994) describes that “the case study is preferred in examining contemporary events, but when the relevant behaviors cannot be manipulated . . . and over which the investigator has little or no control” (p. 8-9). A case study approach is a suitable method to “explore those situations in which the intervention being evaluated has no clear, single set of outcomes” (Yin, 1994, p. 15). In this case study, the following research questions were addressed:

1. What does the Recreation Therapist (RT) do to facilitate Leisure Connections?
2. How is the facilitation experienced by group members?

The primary research question for this study assumed that what the Recreation Therapist ‘did’ included utilizing a range of therapeutic techniques and group facilitation strategies in response to her perceptions of group members’ needs, readiness, and group processes. Thus, her “doing” included more than physical actions. In order to better understand how

the RT selected therapeutic techniques and strategies in the group, a second, subsidiary question was posed: “How is the Recreation Therapist’s facilitation experienced by group members?”

Case Study Questions

The purpose of creating case study questions is to direct the researcher during data collection. According to Yin (2003) the main purpose of the case study questions are “to keep the investigator on track as data collection proceeds” (p. 74). Also, questions may be used as prompts during a case study interview. As suggested by Yin (2003), “a set of substantive questions reflecting your actual line of inquiry” should focus the field notes (p. 73). Miles & Huberman (1994) support the use of questions to help the researcher focus the data collection, and suggest that “unless something has an obvious, direct, or potentially important link to a research question, it should not fatten your field notes” (p. 25).

Following the methods for developing a case study protocol outlined by Yin (2003) this researcher developed the following case study questions used to direct this researcher during data collection:

1. What actions are being carried out by the Recreation Therapist?
- 1b. What group leader interventions are used by the Recreation Therapist?
2. What is the interaction between the participants and the Recreation Therapist?
3. What are the noticeable reactions and changes in the participants as the session progresses?

Prior to each data collection period this researcher read and reviewed the case study questions in preparation. During data collection the case study questions were used

as a guide to remind this researcher to focus observations and questions on what is most important to this study.

Procedures in the Field

This researcher prepared for data collection in an organized and careful manner. Emphasis was focused on adhering to the case study protocol procedures as outlined by Yin (2003). Preparation also included attending a workshop on trauma facilitated by staff of the *Program for Traumatic Stress Recovery (PTSR)*; attendance at the PTSR assessment week and three sessions of Leisure Connections to become familiar with the program and the group; nine hours of software program training in QSR NVivo 7 from the Principal Investigator, discussions during research team meetings, and mentoring from this researcher's Graduate Advisor and Committee Members.

Site and Participant Selection

Six participants were recruited from the in-patient population of the *Program for Traumatic Stress Recovery (PTSR)*. Following the protocol outlined by the Principal Investigator, the researcher attended the community meeting; a mandatory component of the PTSR, to explain the purpose of the study and recruit participants. At the community meeting, all patients were informed of the researcher's presence in the PTSR. After the community meeting, all patients who were scheduled to attend the next block of Leisure Connections were contacted by this researcher to arrange an initial meeting. A face-to-face meeting was scheduled where the purpose of the research was again explained to participants, with the opportunity to have any questions and concerns clarified, as they related to the study. All patients were given a combined Letter of Introduction and

Informed Consent Form (Appendix D). The patients indicated their willingness to participate in the study by providing their signature. Recruitment lasted for two days prior to the start of the next block of Leisure Connections.

A maximum of eight patients are involved in Leisure Connections group. Initially, seven patients signed up to attend the observed block of Leisure Connections. Six agreed to participate in the current study. Just prior to the start of the first session of Leisure Connections the researcher learned that one additional patient had been added to the group. The researcher waited in the hall before Leisure Connections started to inform the patient of the study. A combined Letter of Introduction and Informed Consent was given to determine a willingness to participate. The patient did not give consent to participate in the study. During data collection, group members who chose not to participate in this study were designated as 'client'. Research participants were designated as 'participant' (Appendix F). The Recreation Therapist was not informed of which patients agreed to participate in this study. In addition, each participant has been assigned a pseudonym in the reporting of this study.

Data Collection

According to Yin (2003) the six sources of evidence most common to case studies are: "documentation, archival records, interviews, direct observations, participant-observation, and physical artifacts" (p. 85). Further, "a good case study will therefore want to use as many sources as possible" (p. 85). Three sources of data were used for this case study. The first source of data included interviews: one in-depth, semi-structured interview with each of the four participants; one in-depth, semi-structured interview with the RT (post LC) and three semi-structured interviews with the RT in response to the

reflective practice questions (post LC sessions 1-3). The second source of data included direct observations during the field visits which were captured in written memos detailing this researcher's impressions. Prior to entering the field, the researcher created an observation protocol which was used during observations to capture the general tone and mood of the room and to indicate seating of participants and RT in the room (Appendix F). The third source of data included documents (Reflection Cards) reporting participants' experience of group.

In addition, one source of quantitative data was collected. As part of the larger research project, responses from the Group Therapy Alliance Scale (Marziali, Munroe-Blum, & McCleary, 1997; Pinsof & Catherall, 1986) were gathered. Participants indicated their response to items on the five-point Likert-type scale. In the current case study, responses to items on the Group Therapy Alliance Scale were examined (as an additional data source for understanding participants' perception of a therapeutic alliance and group cohesion in relation to their interview data).

Development of the Interview Guide (Participant)

A semi-structured interview guide was developed by the Principal Investigator of the larger research project, using seventeen open-ended questions. The interview guide was pretested and modified during two prior pilot studies leading up to the larger research project. The questions related to factors that contributed to the participants' experience of leisure connections and their understanding of leisure after involvement in group. An additional eighteen questions related to group facilitation, group cohesion, and therapeutic alliance were developed by the researcher with guidance from the thesis advisor, and added to the interview guide (Appendix A). Revised interview questions

relevant to this current case study are italicized, and prompts that were added for this study appear in upper case (Appendix A). The interview guide was used for all interviews with participants. During the observations of the Recreation Therapist's techniques, prompts were modified to understand how this facilitation is experienced by group members (Appendix A).

Development of the Interview Guide (Recreation Therapist)

The Recreation Therapist strongly believes that her awareness as a self-reflective practitioner impacts her facilitation of Leisure Connections (Griffin, 2005). Following each of the three sessions of Leisure Connections the Recreation Therapist responded to four reflective practice questions about the group process. The reflective questions were developed in collaboration with the Principal Investigator, and the Recreation Therapist:

1. What stood out in my awareness about the experience of group?
- 1b. How did that awareness influence my decisions, feelings, actions during group?
2. What could I have done differently or kept the same given my awareness?
3. What stood out in my awareness about myself in the group experience?
- 3b. How did that awareness influence my decisions, feelings, actions during group?

What have I learned about myself?

At the completion of Leisure Connections, the researcher conducted an in-depth, semi-structured interview with the Recreation Therapist using an interview guide (Appendix H). Examples of interview questions include: 1) As a group leader, what do you do to facilitate Leisure Connections? 2) As a group leader, what do you feel you do well? The focus of this interview was on the facilitation techniques used during Leisure Connections, as perceived by the Recreation Therapist. The interview questions consider

the techniques used by the Recreation Therapist during the observation periods, as well as patterns and themes that emerged, debriefing after group, reference to written memos, and responses to the reflection questions.

Direct Observations, Documented as Written Memos

In this study, direct observation methods were used to describe how the facilitation of activities and the use of therapeutic techniques, in the context of Leisure Connections group, were experienced by group members. Data were gathered in the field using direct observations of 3 sessions (one block) of Leisure Connections occurring over the span of two weeks. Sessions were scheduled for seventy minutes. In addition to describing the physical environment of the room and how it changes from session to session, the mood and tone of the group members were observed and recorded. Observations focused on: 1) interactions among group members and between group members, and the therapist; and 2) participants' and Recreation Therapist's dialogue and movement during group.

According to Patton (2002), observational methods require discipline, and "preparation has mental, physical, intellectual, and psychological dimensions" (p. 261). Approaching fieldwork in this manner will improve the "accuracy, authenticity, and reliability" of observations (p. 261). Written observation notes were recorded to include: a detailed description of the physical setting, including a thorough description of the group room (level of lighting, ceiling height, temperature, and noise level). The approximate layout of the group room was described in the diagram created by this researcher. Seating arrangement of the participants, and the Recreation Therapist during the experiential component was identified in the diagram. A short-form coding system

was used as a guide to indicate the location of group members in relation to each other and the Recreation Therapist (Appendix F). Physical and verbal interactions between group members, as well as with the Recreation Therapist were observed and noted. Cues that indicated a modulation or change in vocal tone were recorded. Physical gestures such as leaning in or away from other group members, and movement throughout the room when identified were recorded.

Prior to direct observation of each group of Leisure Connections, this researcher arrived early to the research site, leaving a minimum of thirty minutes to mentally prepare for data collection; reviewed the propositions and research questions, and the case study questions. A brief check-in occurred prior to the start of group with the Recreation Therapist, to update any administrative tasks associated with group and/or group members.

During the experiential components of Leisure Connections, observations of the therapeutic techniques used by the Recreation Therapist were described using as much detail as possible. Participants' response to the RT's facilitation; their observed actions, behaviours, and dialogue during the experiential exercises were noted. Interactions between individual group members and the group leader were noted, as well as interactions among group members. Levels of participation and engagement between group members and the Recreation Therapist were described in as much detail as possible in the observation notes. Conversation and statements made by the RT and participants, including reflective comments and group interruptions, were recorded throughout the sessions.

The research questions and propositions were carried with this researcher in a binder and accessible during the entire data collection procedure. As well, reference to the case study questions was made during this process, which helped to direct and focus the observation record. A noted strength of direct observations is the real-time and contextual sources of data collected. Observations are recorded as events; as people's lived experiences occur in the natural setting (Miles & Huberman, 1994). In contrast, it is a time-consuming method that may be hindered by researcher presence and skill, resulting in selectivity of data collection (Yin, 2003). To account for any discrepancies that may have occurred, this researcher used available resources such as seeking out the Principal Investigator for clarification, debriefing with the Recreation Therapist before and after each session and paying close attention to field procedures outlined earlier.

Written Memos

The researcher created a structured memo for observations; writing general impressions and considering case study questions after each session of LC (Appendix J). The recorded notes were then transcribed and written as a memo. Throughout the duration of the study, the researcher also recorded personal thoughts and insights in a journal. After each direct observation and at completion of the interviews, the researcher recorded journal notes with brief descriptions. The descriptions included ideas for themes and categories to be considered during the analysis phases of the research. These journal notes were transcribed as memos.

Group Member Reflection Cards

As part of the therapeutic process of Leisure Connections, the Recreation Therapist asked group members to complete a reflection card immediately after each session. Reflection cards were completed in the group room. The questions were created by the Recreation Therapist. The two questions are:

1. What specifically did you notice about yourself in today's session?
2. How does this awareness about yourself impact the choices you make in your free time or in social relationships?

Reflection cards were collected after completion of each session and returned to the participant at the end of the last session. The questions were intended for personal reflection on the participants' experience of group, and may provide information for the facilitator about participants' progress in group. Although the reflection cards were not specifically designed for the purpose of data collection, they were used as a data source, in the form of feedback from group members about their experience of group and the Recreation Therapist's facilitation techniques. In this study, responses from the reflection cards were considered as an additional data source for triangulation (Yin, 2003).

Group Therapy Alliance Scale

Participants were asked to complete an adapted version of the Group Therapy Alliance Scale (Marziali, Munroe-Blum & McCleary, 1997; Pinsof & Catherall, 1986) after the first and third session of Leisure Connections (see Appendix B). All group members rated statements that are indicators of therapeutic alliance, group cohesion, and leader behaviour. The scale asked participants to indicate their response on a 5-point Likert scale (5=strongly agree, 4=agree, 3=neutral, 2=disagree, 1=strongly disagree).

Participants responded to statements from the following five subscales: Group leader and individual participant; group leader and the group; group members about the leader; group members and participant; and overall satisfaction with the group. To compare participants' perception of a therapeutic alliance against their interviews, this researcher compared responses on items to the Group Therapy Alliance Scale. This data contributed an additional source of evidence referred to as triangulation (Yin, 2003).

Data collected for the qualitative case study included the following sources from the participants in this study:

- Written field notes during observation of Leisure Connections group (sessions 1-3); over the span of two weeks (Monday and Wednesday of the first week and the following Wednesday). Each session lasted for seventy minutes. These notes were transcribed verbatim.
- In-depth, semi-structured interviews with four research participants which varied between 25 and 80 minutes in duration and were conducted within 4 days of the last session of LC group. These interviews were audio-recorded and transcribed verbatim.
- Reflection Cards completed by all six participants at the end of sessions 1 and 2. The Recreation Therapist collected the cards after the first two sessions and photocopied them for this researcher. The reflection cards were returned to participants at the end of the last group. The third reflection card was not used as a data source in this study. Contents of reflections cards were transcribed verbatim.

- Descriptive responses to items on the Group Therapy Alliance Scale (Marziali, Munroe-Blum & McCleary, 1997; Pinsof & Catherall, 1986) completed by six participants after sessions 1 and 3 of Leisure Connections.
- Responses to the reflective practice questions captured in three semi-structured interviews (26 and 36 minutes in duration) with the Recreation Therapist immediately following each session of Leisure Connections (Appendix I). Interviews were audio recorded and transcribed verbatim. The decision to audiotape the RT's response to reflective practice questions was made by this researcher based on the rapid vocal pace of the RT; recording the questions as an interview was a method to fully capture the RT's experiences of group.
- One in-depth, semi-structured interview with the Recreation Therapist immediately following the last session (Appendix H). This interview was audio-recorded and transcribed verbatim capturing additional thoughts and reflections shared by the Recreation Therapist.

Table 1 summarizes the data completed for each participant. Data collection that was not completed from participants appears blank.

Table 1

Completed Data Components

	Observation Notes LC Session #1	Observation Notes LC Session #2	Observation Notes LC Session #3	Reflection Cards (2)	Group Therapy Alliance Scales (2) at LC Session 1&3	Interview Post Leisure Connections
Brian	×		×	1 of 2	×	
Tina	×		×	1 of 2	×	
Wade	×	×	×	×	×	×
Nancy	×	×	×	×	×	×
Sara	×	×	×	×	×	×
Derek	×	×	×	×	×	×

Data Management

The researcher transcribed all data sources into word documents in the following order; memos, observation field notes, participant interviews, interviews with RT, reflective practice questions (RT), and the reflection cards. Each audiotape of the interviews was reviewed; listened to and compared for accuracy to the transcripts. Revisions were made to the transcripts when discrepancies were identified. After being read twice for accuracy all data sources were then entered into NVivo 7 (QSR, 2005) for analysis. Data from the Group Therapy Alliance Scale (Marziali, Munroe-Blum & McCleary, 1997; Pinsof & Catherall, 1986) were incorporated into a Microsoft Excel spreadsheet for analysis by the Principal Investigator.

In the current study, the case study database included all data sources; field observation notes, interview transcripts, memos, reflection cards, and Recreation Therapist reflective practice questions, as well as analysis of the data. The data contained in the case study database were stored both in the NVivo 7 project file and backup copies were stored in an accessible but secure location.

To maximize the benefits of using multiple sources of evidence three principles were followed: Principle 1, use multiple sources of evidence; Principle 2, create a case study database; and Principle 3, maintain a chain of evidence (Yin, 2003).

The multiple sources of evidence used in this study are in keeping with Principle 1, and were considered a strategy that assisted in the development of “converging lines of inquiry, a process of triangulation” (Yin, 2003, p. 98).

Principle 2 as suggested by Yin (2003) is building a case study database, which made storage and retrieval of case study data (notes and documents) more accessible during the analysis process. The use of a case study database is suggested as a means to organize notes and documents for retrieval or review by other investigators. A formal and presentable case study database “increases markedly the reliability of the entire case study” (Yin, 2003, p. 102). Case study notes are a common component of a database (Yin). In this study, the case study database was developed as notes were written and entered into QSR NVivo 7 (QSR, 2005). All case study notes were entered into the computer assisted data management program QSR NVivo 7 as soon as possible following direct observations of LC, interviews, and document retrieval (Reflection Cards). The use of the computer assisted data management program (QSR NVivo 7) allowed for efficient access and retrieval during the analysis process.

For the purpose of this study, all data were entered as word documents into QSR NVivo 7 (QSR, 2005). As suggested in the literature, “analysis programs speed up the process of locating coded themes, grouping data together in categories, and comparing passages in transcripts or from field notes” (Miles & Huberman, 1994, p. 442). Software programs are used to manage, move, and retrieve data. Documents entered into the QSR NVivo 7 case study database were time and date stamped, which helped ensure adherence to Yin’s Principle 3, maintain a chain of evidence.

Storage and security of the data was ensured through the use of a protected password on this researcher’s personal laptop computer. Therefore, access to the case study database created in QSR NVivo 7 was available only to: this researcher, the Principal Investigator, and the Graduate Supervisor. A back up of the computer hard drive was updated throughout data collection and secured with hard copies of the documents. These were stored in a secure location in the researcher’s home office.

Data Analysis

This study followed the data analysis strategy described by Yin (2003) as “relying on theoretical propositions” (p. 111) and Miles & Huberman’s (1994) “components of data analysis” (p. 12). Also described by Yin (2003), one strategy of case study analysis is to “follow the theoretical propositions that led to your case study” (p. 111). Theoretical propositions guide the analysis, focus attention on the data, and assist the researcher to organize the entire case study.

Miles and Huberman (1994) provide an interactive model of the components of data analysis (Figure 2). According to the authors, qualitative data analysis consists of three activities: data reduction, data display, and conclusion drawing/verification. As

described in Figure 2 the approach to the activities of data collection and analysis form an interactive cyclical process. For example, the process of data analysis begins “before, during, and after data collection in parallel form, to make up the general domain called analysis” (p. 11-12). Inclusion of the interactive model (Figure 2) does not imply that data reduction is a linear process; rather, the three analysis activities are related to each other in a continuous process “as analysis episodes follow each other” (Miles & Huberman, 1994, p. 12).

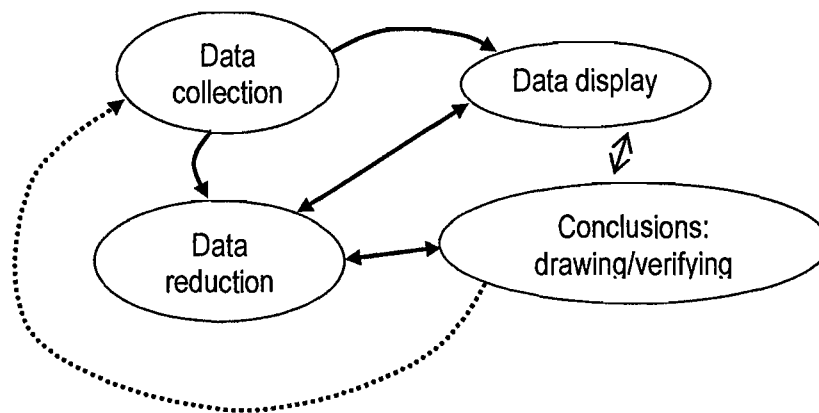


Figure 2. Components of data analysis: Interactive model.

Note. Adapted from Miles & Huberman (1994).

Data reduction, according to Miles & Huberman (1994), is a process that continues throughout data collection until completion of the case study report. Data reduction involves episodes of selecting and reducing potential data. As ideas for data display emerged, this researcher continued with the process and conclusions that emerged were used to further revise the data display and data reduction. Miles & Huberman describe data reduction as a process which involves “selecting, focusing, simplifying, abstracting, and transforming” the data collected during fieldwork (p. 10). Data reduction

occurs as the researcher makes analytical choices of, “which data chunks to code and which to pull out, which patterns best, summarize a number of chunks, which evolving story to tell” (Miles & Huberman, p. 11). In this study, the data reduction process continued as the researcher read and reviewed the memos, observation field notes, verbatim transcripts from participant interviews and interviews with the RT, participant responses to reflection cards, and lastly, responses to the Group Therapy Alliance Scale (Marziali, Munroe-Blum & McCleary, 1997; Pinsof & Catherall, 1986). To increase familiarity with the data this researcher read through the above documents numerous times, and notes about general ideas and impressions that emerged were written in the margins.

An initial set of themes were developed as this researcher re-read each data source and used a yellow highlighter to mark general ideas emerging from the data. Next, this researcher again read each data source and identified additional themes emerging in the data by highlighting them in green marker. A third process of data reduction occurred as this researcher then used a pink highlighter to identify themes, and patterns in the themes, which reflected the theoretical propositions. The process of data reduction continued using the qualitative software program NVivo 7 (QSR, 2005) to create free nodes which reflected these initial themes. Free nodes created in NVivo 7 represented the preliminary concepts; initial groupings or themes that emerged from the data and described the actions, interventions, interactions, and reactions between the participants and the Recreation Therapist.

Throughout the data analysis process memos were created in NVivo 7 to reflect general impressions and key concepts that emerged. According to Miles & Huberman

(1994) memo writing is viewed as a necessary step toward analysis and assists in the “clustering” function, pulling together commonalities (p. 74). As data analysis and reduction continued this researcher created categories of tree nodes from clusters of similar free nodes; target words and phrases were used to label the tree nodes in NVivo 7 (QSR, 2005). Coding categories emerged from the data and were developed based on the 10 Group Leader Interventions (Morran, Stockton, & Whittingham, 2004), which the researcher used as a guide during observation (Appendix G); the conceptual framework and the theoretical propositions. Using NVivo 7 (QSR, 2005) this researcher continued to code all data sources into tree nodes. The tree nodes are presented as the themes presented in Chapter Five of this study.

Data display, the second activity, refers to the process of organizing information “into an immediately accessible, compact form”, which assists the researcher to either, continue the step-by-step analysis or draw conclusions (Miles & Huberman, 1994, p. 11). Data display includes the use of tree diagrams, matrices, graphs, charts, and networks, and as Miles & Huberman state, “as with data reduction, the creation and use of displays is not separate from analysis, it is a *part* of analysis” (p. 11). Data display included writing up themes with thick descriptions using verbatim quotes from participants and the Recreation Therapist. Matrices and tables were also created to explore the patterns within and between the themes (tree nodes). Final matrices are included in Chapter 5. The data analysis process was guided by the conceptual framework and the theoretical propositions.

Conclusion drawing and verification, the third activity, is the process undertaken by the researcher “[f]rom the start of data collection . . . to decide what things mean—

noting regularities, patterns, explanations, possible configurations, causal flows, and propositions” (Miles & Huberman, 1994, p. 11). During this phase, the researcher compared and contrasted information, taking note of patterns and themes, looking for negative cases, and verifying findings with the Thesis Advisor, the Principal Investigator and the Recreation Therapist. This process continued until all potential relationships, themes, and meanings had emerged from the data. Verification occurred during analysis as this researcher revisited the audiotapes; memos and observation field notes; reviewed notes from the debriefing (interviews) with the Recreation Therapist; and initiated discussion with other research team members.

During the coding process, the researcher met for guidance and supervision with her thesis advisor. The meetings were used to discuss the coding and analysis of all data sources. As the analysis process continued, scheduled meetings occurred with committee members who have expertise in qualitative case study research.

Strategies to Promote Rigor and Trustworthiness of Research

There are guidelines in place to promote rigor in qualitative research. Trustworthiness is a term considered parallel to the term rigor. In qualitative research, four criteria are suggested as promoting trustworthiness of the findings: credibility, transferability, dependability, and confirmability (Lincoln & Guba, 1986)

Lincoln & Guba (1986) as cited in Patton (2002), describe credibility of qualitative inquiry, “as an analog to internal validity”, is concerned with providing analysis that is judged as quality research and believable (p. 546). In this study, the concept of researcher reflexivity was used to increase credibility. According to Patton (2002) “reflexivity reminds the qualitative inquirer to be attentive to and conscious of the

cultural, political, social . . . and ideological origins of one's own perspective and voices of those one interviews and those to whom one reports" (p. 65). Credibility is also used to establish trustworthiness. To increase the trustworthiness of the findings, throughout this study, the researcher used rigorous research methods, researcher reflexivity and triangulation.

Transferability, as a criterion of trustworthiness, asks if findings can be transferred to other settings with similar characteristics (i.e., to another group of trauma survivors). To distinguish quality in qualitative research, Patton (2002) refers to transferability "as an analog to external validity" in quantitative research (p. 546). In this study, direct quotations used as thick, rich contextual descriptions of the participants' experiences will enhance the transferability of the study to similar settings.

Patton (2002) describes dependability "as analogous to reliability" (p. 546) and refers to the extent that the researcher follows "systematic data collection procedures" (p. 51). In this study, an audit trail of the research and analysis process was generated through the creation of a case study database and the use of the QSR NVivo 7 program.

Dependability means the methodological process is systematically followed (Patton, 2002). Similarly, the principle of maintaining a chain of evidence refers to the ability of an external observer; an investigator or the reader of a case study, to follow the methodological research process. As Yin (2003) describes, incorporating the use of a case study database to maintain a chain of evidence (audit trail) "increases markedly the *reliability* of the entire case study" (p. 102).

Confirmability is described by Patton (2002) as similar to objectivity, and consists of "testing ideas, confirming the importance and meaning of possible patterns, and

checking out the viability of emergent findings with new and additional cases” (p. 239). Through the use of a case study database, this researcher created an audit trail; field notes, memos, and researcher journal, which allowed for an examination of the research and analysis process (Lincoln & Guba, 1985). The audit trail is accessible from the QSR NVivo 7 qualitative software program and hard copy documents.

According to Patton (2002) data triangulation means “comparing and cross-checking the consistency of information derived at different times and by different means within qualitative methods” (p. 559). Further, triangulation is referred to as the use of more than one source of measurement, approach, or perspective; it is a combined method, for strengthening the quality and credibility of qualitative research (Barker, Pistrang & Elliott, 1994; Yin, 2003).

There are four types of triangulation:

1. of data sources (data triangulation)
2. among different evaluators (investigator triangulation)
3. of perspectives to the same data set (theory triangulation)
4. of methods (methodological triangulation) (Patton as cited in Yin, 2003, p. 98-99).

Triangulation of data sources occurs when facts and evidence of the case study are supported by multiple sources of data. Multiple sources of data are used to “corroborate the same fact or phenomenon” (p. 99). For example, in this study, the following multiple sources of data were used; direct observations of three sessions of Leisure Connections, semi-structured interviews with four participants and the Recreation Therapist, completion of reflection cards, debriefing sessions with the RT after each session of LC,

and completion of the Group Therapy Alliance Scale (Marziali, Munroe-Blum, & McCleary; Pinsof & Catherall, 1986) by six participants. Using multiple sources of data is considered as an advantage, and is described by Yin (2003) as “converging lines of inquiry” (p. 98). In this study, data sources from the direct observations, participant interviews, interviews with the RT, and the debriefing sessions with the RT were systematically and diligently compared to identify where information from the sources was congruent or incongruent. These comparisons were made during data analysis and again when conclusions were being drawn. These findings are presented in Chapter 5. For example, when data about the group leader intervention ‘feedback’ were compared, data about feedback was consistent and evident in the observations, the RT reflections, and two participant interviews. For the group leader intervention ‘interpreting’, there was data in the observations and the RT interview, and in one participant interview. Second, investigator triangulation was employed in this study as the larger research project involved multiple investigators; the Principal Investigator, this researcher, and the research team. Investigator triangulation also occurred when the researcher met for supervision with her thesis advisor to re-code during the analysis process. Third, the conceptual framework and propositions contribute to theory triangulation by capturing multiple perspectives of data sources.

Fourth, methodological triangulation refers to multiple data collection methods employed to gather information about the Recreation Therapist’s facilitation of Leisure Connections, and the participants’ experience of this facilitation.

Ethical Considerations

Preparing for the data collection phase, the researcher participated in assessment week at the *Program for Traumatic Stress Recovery (PTSR)*, and attended three sessions of Leisure Connections for practice observation. A client confidentiality form was reviewed and signed by the researcher.

All patients in the *Program for Traumatic Stress Recovery (PTSR)* were informed of the Leisure Connections research project prior to recruitment and data collection. Participation was voluntary and at any point during the research process a participant could withdraw from participating. Any data gathered at that time would be destroyed. For the purpose of this study, participants included in the research study were referred to as participants, while non-participants attending Leisure Connections (during data collection) were referred to as clients.

After the completion of the interviews the researcher handed all participants a Letter of Appreciation to acknowledge their participation in the study (Appendix E). The researcher of this study did not send a summary of research findings to participants for initial feedback about the group experience (member checking). As per the larger research project, a written summary of the findings will be made available to participants by mail or by contacting the Recreation Therapist at the Homewood Health Centre at the completion of this phase of the research study.

All participants in the study read and signed a Combined Letter of Introduction and Informed Consent (Appendix D). Ethical approval for this study has been received by the Research Ethics Board at Brock University (file # 05-349) and the Ethics Committee at Homewood Health Centre.

Case Study Report

The subsequent findings and discussion chapters of this study follow the format of a written case study report for use with a single-case study. Yin (2003) describes that this type of case study composition, “follows a series of questions and answers, based on the questions and answers in the case study database” (p. 147). As stated by the author, reporting of a case study “means bringing its results and findings to closure” (p. 141). In this study, the findings from the analysis were organized around the research questions, case study propositions and the conceptual framework. The case study report includes a written narrative with matrices and tables to display the findings.

Summary

This chapter described the methods followed for data collection and data analysis. The methods follow procedures for qualitative case study research described by Yin (2003) and procedures for data analysis described by Miles and Huberman (1994). A qualitative case study approach was selected to describe the Recreation Therapist’s facilitation techniques used in Leisure Connections, and explore how participants’ experienced this facilitation.

Chapter Five: Findings

In this chapter the findings are presented in two sections. Prior to introducing the themes, in the first section, a brief narrative description of the case and a summary describing each of the observed sessions of Leisure Connections is presented. The second section presents an overview of the major findings; themes that emerged in response to the two research questions. The first research question, “How is the facilitation experienced by group members?” revealed three themes: *Group Leader Interventions*, *Recreation Therapist’s Actions*, and *Recreation Therapist’s Preparation and Reflections*. The second research question, “How is the facilitation experienced by group members?” generated three themes: *Group Members’ Experience of Therapeutic Alliance*, *Group Cohesion*, and *Prior Influences and Assumptions*. These themes are comprised of different elements or components of themes. For example, the theme, *Recreation Therapist’s Actions* includes descriptions of: movement in the room, body language, creates visual, etceteras.

For the current study, due to a statutory holiday, Leisure Connections group occurred three times instead of four, over the span of two weeks. Each session lasted seventy minutes. The six participants were at different treatment phases in the *Program for Traumatic Stress Recovery (PTSR)*. At the start of this block of Leisure Connections, three participants were in week two and two participants were in week five, while one participant was soon to be discharged. Four of the participants were attending the PTSR for the first time. One had transferred from another unit in the hospital. Of the six participants, four attended all three sessions of Leisure Connections and completed the interview (see Table 1). Two participants missed session two and the interview. One of

them left the PTSR before the interview could be completed. The other did not come to two scheduled appointments for the interview.

The following description of the six participants resulted from responses to informal questions posed during the semi-structured interview process. Other clinical information was obtained with consent from patient charts and/or nursing staff. Some participants in the study had disclosed struggling with co-occurring issues such as body image, mental illness and/or substance abuse. Participants in the current study have experienced different types of trauma including: childhood sexual abuse, emotional abuse, combat related and work-related trauma. The participants ranged in age from between 28 and 55 years.

Leisure Connections: Case Study Report

The *Program for Traumatic Stress Recovery (PTSR)* provides an intensive eight-week in-patient program for survivors of trauma. Part of the criteria for involvement in the PTSR program is that participants have experienced some form of trauma in their life. Wright & Woo (2000) are clinical members of the PTSR treatment team, and report that 95% of the patients admitted to this program fulfilled the criteria for PTSD; with 33% receiving the diagnosis prior to admission. The twenty-eight bed (PTSR) treatment program is available primarily for individuals who have access to private health care insurance or independent financial resources. At the time of this study, two beds were covered by the Ontario Health Insurance Plan (OHIP). The wait-list for patients with private health care insurance was approximately six to twelve weeks, and for those without private insurance, the wait was eighteen months or longer. Admission to the PTSR program occurs weekly and patients first enter the assessment phase. Most patients

attend therapy groups with participants who were admitted to the program on the same date.

Leisure Connections is an elective group offered within the *Program for Traumatic Stress and Recovery (PTSR)* and is facilitated by a Recreation Therapist. Group members are enrolled in Leisure Connections by self-referral or recommended to the group by a member of the treatment team. Patients may begin LC at any point after their initial assessment week. Consequently, patients enter LC at different points during their eight-week stay. For example, there may be patients in Leisure Connections who are in week two of their program, while others may be in week six. Leisure Connections group includes both male and female patients. In general, patients range in age from 18 to 70 years, with over half of the population being female (Wright & Woo, 2000).

The usual format of Leisure Connections is that it occurs twice per week on Mondays and Wednesdays over the span of a two-week period (one block). Due to a statutory holiday, only three sessions of Leisure Connections were held during the two week period in which the study was conducted. Each of the three group sessions were scheduled for seventy minutes.

Leisure Connections

The three observed sessions are described briefly, to give the reader an overview of each session. Each session was scheduled for seventy minutes. The first session started a few minutes late. The second session started five minutes late. The third session started on time but two participants arrived up to ten minutes late. Two participants did not attend the second session and everyone was present at the other two sessions. Each session started with an introduction, or bridge from the previous session, lasting about

two minutes. The psycho-educational component occurred in sessions 1 & 3 only. For sessions 2 and 3, there was also an experiential component with debriefing. Each session ended with the RT handing out reflection cards for participants to complete. The content of each session is described in the following paragraphs.

The first session began with the RT describing the format and purpose of Leisure Connections. She referred to a handout, explained the psycho-educational and experiential components, and the reflection cards. This lasted approximately three minutes. The psycho-educational component started with an icebreaker activity led by the RT. She asked the group to share their responses to five statements that had been written on the board. As the responses slowed the RT shifted the focus. The psycho-educational component continued as a discussion to include four different ways to understand leisure; through activity, state of mind, choice and free time. The RT moved back and forth between sitting with the group and writing notes on the whiteboard. Throughout the session two participants wrote notes intermittently. Session #1 closed as the RT thanked the group for their participation and handed out the reflection card.

The second session of Leisure Connections began with a bridge of the previous session as the RT asked the group, “does anyone remember last week?” She responded to the group as they shared their experiences about the last session. The RT introduced the experiential component by asking group members to pair up with someone with whom they felt safe. The experiential component started as the RT moved her hands in the air in the motion of “Pat-A-Cake” and asked the group to do the same with their partner. This lasted for approximately one minute. Throughout the experiential component the RT instructed the group to make three changes to the basic clap pattern. The RT debriefed

each change in pattern with the group before giving direction for the next change and round of Pat-A-Cake. In total, the experiential component, Pat-A-Cake, lasted for approximately eight minutes. The RT moved back and forth between standing and sitting with the group while she gave directions to change the basic clap pattern. Throughout the session all participants participated in the experiential component followed by discussion. Session #2 closed as the RT thanked the group for their participation and handed out the reflection card.

The third session began with the RT bridging from the previous session. She asked the group if anyone remembered the last session. The RT responded to the participants who shared their experience. She introduced the session, stating that the format of the third session included both psycho-educational and experiential components. The RT asked the group to respond to a series of three questions. The psycho-educational component continued, led by the RT, as a discussion of ways to help the group recognize healthy leisure choices and pursuits they are involved in. The RT moved back and forth between the group writing notes on the whiteboard. The experiential component started as the RT asked the group to stand and form a circle. She led the experiential component by tossing a bean bag across the circle. Throughout the experiential component approximately eight bean bags were tossed between and among the group and the RT. The experiential component, Bean Bag Toss, lasted for approximately seven minutes. Throughout the session all participants participated in the experiential component. The RT debriefed the experiential component with the group as a discussion and then returned the reflection cards from the previous two sessions. Session #3 closed as the RT thanked the group for their participation and handed out the

reflection card. She asked the group to share any observations about their returned cards. For a detailed description of the three sessions of Leisure Connections see Appendix K.

Overview of the Major Findings

The sections that follow present the themes that emerged in relation to the two research questions that guided this study. Descriptions from the observation notes and verbatim quotes taken from the interviews with participants and the RT are used to describe the findings. When quotes are presented, pseudonyms of participants' names are used. The data source of each quote is indicated, for example, observation notes, interview with participant, or interview with RT.

Six themes emerged in response to the two research questions. In relation to the first research question, "What does the Recreation Therapist do to facilitate Leisure Connections?" the findings generated three themes:

1. *Group Leader Interventions*. This theme describes the therapeutic interventions used by the Recreation Therapist to facilitate Leisure Connections. For this study, the researcher used the 10 group leader interventions reviewed by Morran et al. (2004) as a guide during the direct observations and analysis. This theme also responds to case study question 1b, "What group leader interventions are used by the Recreation Therapist?"
2. *The Recreation Therapist's Actions*. This theme identifies a specific action used by the Recreation Therapist to facilitate group. This theme also responds to case study question 1, "What actions are being carried out by the Recreation Therapist?" This theme includes descriptions of: movement in the room, body

language, vocal modulations and pausing, scans the room and makes eye contact, and creates a visual.

3. *Recreation Therapist's Preparation and Reflections*. This theme includes the Recreation Therapist's description of her experience of her role as group leader. This theme includes descriptions of: RT's decision making, self-preparation and the reflective practitioner, and managing time constraints.

In relation to the second research question, "How is the facilitation experienced by group members?" three additional themes emerged:

1. *Group Members' Experience of Therapeutic Alliance*. This theme describes the presence of a therapeutic relationship among participants and between the group members and the Recreation Therapist. This theme includes descriptions of: group members' description of therapeutic alliance with RT, comfort and safety in group, group therapy alliance scale, and interpretation of the group therapy alliance scale.
2. *Group Cohesion*. This theme includes the group members and the Recreation Therapist's description of their experience of the group dynamic. The themes, *Group Members' Experience of Therapeutic Alliance* and *Group Cohesion* also respond to case study question 2, "What is the interaction between the group members and the Recreation Therapist"? This theme includes descriptions of: group members' description of group cohesion, RT's description of group cohesion, and suggestions for change to LC.
3. *Prior Influences and Assumption*. In addition, it was found that the context of Leisure Connections within the *Program for Traumatic Stress Recovery*

influenced both what the Recreation Therapist did and how the group members experienced facilitation. In this theme, group members describe the impact of previous interactions with the RT and influences from peers on their experiences of Leisure Connections. Details of the findings are described with illustrative quotes in each of the following subsections. The theme also includes the influences and assumptions about participants and Leisure Connections as described by the RT.

In response to case study question 3—“What are the noticeable reactions and changes in the group members as the session progress”?—the group members’ experiences of the Recreation Therapist’s facilitation are explored in the following two descriptions of *Group Cohesion*: group member’s description of group cohesion and interpretation of group therapy alliance scale.

Group Leader Interventions

According to Morran, Stockton, & Whittingham (2004) ten group leader interventions are grouped into two categories. The first category is protecting group members/promoting safety and includes: protecting, blocking, and supporting. The second category is energizing/involving group members and includes: drawing-out, modeling, linking, processing, interpreting, self-disclosing, and feedback. These interventions capture the observed facilitation techniques used by the RT to facilitate Leisure Connections. This researcher used the ten group leader interventions as a guide during the observation and analysis. Each of the group leader interventions are presented and described in the order of the categories indicated above.

Protecting.

Protecting is a broad category of group leader interventions aimed at preventing members from taking “unnecessary psychological risks” in the group before they are ready (Morran, Stockton, & Whittingham, 2004, p. 93). Protecting interventions may be indirect and include selection of members (inclusion/exclusion criteria), the modeling of caring for group members, and the establishment of group norms (Morran et al., 2004). The inclusion/exclusion criteria for LC are that people cannot attend during assessment week and it is an elective or voluntary group in the context of the PTSR. Indirect protecting occurs informally, when a member of the treatment team (including the RT) refers a patient to Leisure Connections based on the team members’ assessment that the goals of the patient or the progress the patient is making in the program are related with the treatment goals of LC. Direct protecting interventions are aimed at stopping a member who is “self-disclosing too much or at a level that is significantly more intimate than the rest of the members” (Morran et al., 2004, p. 93).

The following example describes how the Recreation Therapist used indirect protecting in the initial stage of group to promote a sense of safety and to establish group norms:

The RT states, this is a closed session group – what that means is that no one else with the exception of [non-participant] will join the group. (Observation note, Session 1).

The Recreation Therapist continued to outline group norms:

She continues to describe the 4 LC sessions and states that due to the Easter holiday this block of LC will only be 3 sessions. [...] She continues to describe that the first two sessions are more educational components [...] I will hand out Reflection Cards at the end of each session. She gives a brief description of what a Reflection Card is. (Observation note, Session 1).

The intervention protecting was referred to by the RT during the interview:

So particularly in the first session, I don't want it to be too threatening for people right of the top. So I may externalize it, like, if this was somebody else, what would you see be happening; if it's too close to home for yourself.

(Interview with RT).

Protecting interventions were observed in sessions one and two, but not used in session three. The RT referred to protecting interventions in the interviews. No participants reflected on the intervention. The intervention, direct protecting, was not observed in LC.

Blocking.

Blocking was used by the RT to protect and/or stop a group member from inappropriate probing, gossiping or invading the privacy of group members. The intervention has been referred to as cutting off or intervening and may be facilitated verbally or non-verbally (Morran et al., 2004). The following quote describes how the Recreation Therapist enacted blocking with group members who were becoming distracted during session #2 of Leisure Connections. The Recreation Therapist intervened by refocusing the conversation and blocking further comments from group members:

Derek: Makes a comment about Wade (intended as a joke). Some group members laugh in response.

Nancy: (directed at Wade) I remember you saying you are a perfectionist.

Wade: Yes. I did always try to do sports perfectly. He begins to list activities: parasailing, golf. The RT then begins to summarize and move into the next part of the group.

RT: So, it sounds as if you are starting to shift the ways you do things; so they are less perfect, less connected to perfection (Observation note, Session 2).

In session #3 the Recreation Therapist used blocking to again redirect a group member who had started to share an experience that seemed unrelated to the momentum of the group's process. The Recreation Therapist used blocking by restating her point

about the power of the present, thus bringing the dialogue back on track, to the present group process:

The RT continues to speak of practice about being present; she asks the group, how much power does the past hold over the present? Then she says this is not to minimize the trauma. She speaks today's date and the time, and says with a slow emphasis, that being here, right now, it (referring to trauma) is not happening.

Sara: I realize that in my leisure activities lately I am preoccupied with what people are thinking about me. The RT responds by going back to the statement about the power of the present. She concludes the discussion with that thought (Observation note, Session 3).

Blocking was observed in LC session two and three but not in session one. One participant reflected on blocking during the interview.

Supporting.

Supportive interventions occur when leaders help to reassure, reinforce, and encourage members to participate in the group. This intervention is appropriate when a member is struggling with old behaviour patterns, feeling unsure about making changes, or withholding their participation to avoid saying something that is seen as wrong (Morran et al., 2004).

Supporting was used by the Recreation Therapist as she introduced the experiential exercise, Pat-A-Cake. The RT offered a supportive statement acknowledging that group members' may be experiencing discomfort, and she encouraged them to reveal any thoughts or feelings that arise. The following quotation is an example from Leisure Connections session #2:

Group members move into pairs, shifting chairs and making conversation, some laughter. As this is occurring, the RT verbally acknowledges that some group members may be sitting with feelings now (in reference to having paired up and being in closer proximity). She continues to introduce the

experiential component; I want you to notice, pay attention to that knee-jerk reaction; speak about whatever you notice (Observation note, Session 2).

The RT also demonstrated verbal support to group members during their participation in the experiential exercise:

The RT watches the group; good, good, keep going she says. She scans the dyads as she stands outside of them. [...] As she asks the group members to stop the Pat-A-Cake exercise, she is saying, beautiful, thank you, thank you. (Observation note, Session 1)

Supporting interventions were observed in all three sessions of Leisure Connections. None of the participants or the Recreation Therapist commented on the supporting intervention in the interviews.

Drawing Out.

Drawing out occurs when a leader directly invites comments and encourages participation from members who share on a surface level, avoiding deeper issues, or with those who find it difficult to share with others. Non-verbal communication such as making eye contact or gesturing to members is also considered drawing out. The leader's use of structured techniques such as dyads, set activities, or asking questions to involve members is also referred to as drawing out (Morran et al., 2004).

To engage participation early in the group, drawing out was used as an intervention in the psycho-educational component of LC session #1 through the use of a structured whiteboard activity. In the following example, participants were asked to share responses to the following five statements written on the board by the RT:

The RT asks the group to look at the board where there are 5 statements listed and she reads:

- 1) My favourite activity in childhood or now is...**
- 2) I don't do it much but I enjoy...**

3) If I didn't have to do it perfectly I would...

4) If I wasn't too selfish I would...

5) If money was no object, I would...

She asks the group to share a response to the statements (emphasizing only if they feel comfortable).

Nancy: Number 3 for me. If I didn't have to do it perfectly I would . . . play.

Wade: Oh, I love to play. I'd play an instrument.

RT: Does a specific instrument stand out?

Brian: Play guitar.

Tina: Number 2, I do not do it much, but I enjoy . . . painting.

RT: Are there any other responses from the group?

Derek: I'm with Number 2. I don't do it much, but I enjoy playing the guitar.

RT: Any others up there?

Nancy: Well, number 5, golf, but it's too expensive.

(Observation note, Session 1)

During the interviews three participants referred to the use of drawing out by the RT during the structured whiteboard activities. Sara noted that the RT used the word brainstorming during the structured whiteboard activity. As Sara described, **"She would say, this is open to everybody, we're going to brainstorm."** Sara added, **"How did she encourage group members to participate? Inviting. She'd say [...] is anybody else feeling the same thing? That kind of thing."** Similarly, Wade noted how the Recreation Therapist used drawing out to encourage group members' participation in the structured activity:

Well if anybody said, if they were talking about a certain subject and they came out with a word, like fun or assertiveness; there wasn't a word that anybody said that she didn't put up on the board (Interview with Wade).

During her interview, Nancy stated, **"She would get people to like, everybody did the bean bag and she would ask questions, and she asked everybody to say at least two answers when she was writing stuff up on the board."**

In session #2 of LC the RT used drawing out to invite comments and participation from group members about the last session. The RT stated, **"Does anyone remember**

last week? Anything left over? [...] Are there other group members who want to share their awareness or feelings about last session? Similarly, at the start of session #3 the RT asked the group, **“Does everyone remember last day? Anything left over?”**

Drawing out was also used in other parts of the sessions. At the conclusion of the experiential exercise, the RT used drawing out during debrief of the activity; inviting and encouraging group members to share comments about their experience. The following example describes the use of drawing out at the end of the Bean Bag Toss:

RT: What do you notice now?

Nancy: I was scared. I gotta be aware of everything and I couldn't.

RT: Again asks, what did you notice?

Wade: I felt focused. Then I'd know it was coming.

Sara: I was wondering why we weren't laughing more.

RT: Responds to Sara's comment; I noticed how even though it was quiet, there were smiles on faces.

Tina: Less tense.

Derek: Happier

RT: Checks with group members by asking, energy up? Is that accurate?

Response from group members is yes (Observation note, session #3).

The RT used drawing out when she returned completed reflection cards to the participants at the end of LC session #3. She asked the group to read what they had written about the two previous sessions and encouraged them to participate by sharing their observations with the group:

RT: Puts her papers away and then she asks the group members to share any observations, to think about, what do they notice about their reflection cards?

Brian: Responds with, a shitty outlook on life.

RT: What might be helpful to try to do it differently?

Derek: Offering what he noticed; positive, I'm consistent throughout groups.

RT: Anybody else notice anything?

Sara: I have a pre-occupation of play . . . of being different.
(Observation note, Session 3)

The intervention drawing out was observed in all three sessions of Leisure Connections. Four participants and the RT commented on the intervention drawing out during the interviews.

Modeling.

Modeling occurs when the leader demonstrates by example the qualities, characteristics, skills and attitudes that members may need to learn to function effectively in group and in other areas of their lives; caring and respect for others, openness, appropriate self-disclosure, and giving and receiving feedback (Morran et al., 2004).

In Leisure Connections session #1 the Recreation Therapist modeled appropriate self-disclosure in response to non-verbal feedback she was receiving from the group. The group had not responded to a question posed by the RT. The following example describes how the Recreation Therapist used modeling:

RT: Am I speaking too quickly? The group members respond, yes.

RT: I am getting the deer-in-the-headlights look. She then adds, in my head it is a lot slower. I can speak fast, I know. Some group members laugh. The RT adds that she will try to slow down (Observation note, Session 1).

Modeling occurred in LC sessions one and two, but not in Session 3. One participant and the RT discussed the intervention modeling during interviews.

Linking.

During the initial group stage, linking was used to encourage interaction among members, and connect what one group member was saying or doing with the concerns of other members in the group. Linking may be used to give direction and organization to the group by focusing on common themes that have emerged during the group sessions. The leader ties together common elements in the communication to help individual

members identify with other group members. Linking is seen as useful in promoting universality, a sense of group purpose, and member cohesion (Morran et al., 2004).

Nancy described the use of linking as:

She would give each individual a chance to talk and say how they felt, and she would like, o.k., you feel like that. Is there anyone else in the room who feels like that? All of a sudden everybody's hand would go up.
(Interview with Nancy)

Sara acknowledged the Recreation Therapist's use of linking in Leisure

Connections as a way to connect and identify with group members' felt experience:

[...] And she would say, maybe, I'm thinking of patty cake, maybe we're mostly talking or listening to these two people, but somebody might go, yeah. She'll go, oh that had meaning for you? Tell us more. So she makes those links and even though that was not my exchange she might have said, oh I noticed you nodding, how's that playing out for you? (Interview with Sara)

The intervention linking was observed in LC sessions one and three, but not in session two. Three participants and the RT referred to or discussed linking in the interviews.

Processing.

Processing interventions occur when the leader and group members capitalized on significant, here-and-now happenings in the group. The use of processing allows the group to reflect on the meaning of their experience, to gain insight, and to better understand their thoughts, feelings and actions. Processing provides a framework to integrate, retain and generalize their group experience to outside situations (Morran et al., 2004).

At the end of each LC session, the RT used reflection cards to process meaning and insight from the group experience; group members were asked to reflect on the session and write anything of significance about their individual experience. The use of

reflection cards offered a different format for group members to process their thoughts, feelings, and actions. In the following example, the RT describes the use of reflection cards for processing group happenings:

[...] The RT then asks group members to think about what stood out for you, about yourself in today's session, and to write this on a reflection card. She hands out the Reflection Cards (Observation note, Session 1).

The reflection cards asked two questions about group members' experience in Leisure Connection group:

1. What specifically did you notice about yourself in today's session?
2. How does this awareness about yourself impact the choices you make in your free time or in social relationships?

Question one responses summarized from participants described lost interest in leisure, self-awareness about choices in leisure, allowing others to control, and feeling cheated, sad and angry for not being allowed to play in childhood. Question two responses from participants described avoidance of leisure and social relationships, the need to practice making choices in free time, awareness of emotions like shame and guilt in leisure, and the need to communicate change. In the following examples, participants reflected on their individual experience of group, writing about insights and awareness in the reflection card responses. One participant responded by stating, **"I noticed I am negative"** (Reflection card, question 1). In a response to question two, a participant added, **"I don't do them [social relationships]"** (Reflection card, question 2). Similarly, another participant commented, **"I noticed that I have fear with leisure"** (Reflection card, question 1). The participant continued, **"I avoid leisure and it is hard to have**

social relationships. I have shame with leisure; I feel that I am not worth it”

(Reflection card, question 2).

The following example depicts how the RT used questions [drawing out] to process the experiential exercise in Leisure Connections session #2:

The RT returns to the dialogue with Nancy and says, so you learned more about trusting your own experience?

Nancy: [Y]ou wouldn’t believe what patty-cake would do to you.

Derek: Adds a humorous comment.

Wade: Watching what happened between Derek and Nancy made it show how it’s more than patty-cake. [...]What it felt like to be in control, to be controlled.

The RT turns and faces Wade, nodding her head and scanning the room to make eye contact with group members as she begins to explain the concept of defensive anger. [...] She makes the connection with defensive anger and laughter, and acknowledges that there was a decrease in the need for control [during experiential exercise].

Nancy: That could work in any relationship.

RT: I’m glad to hear that people are connecting it (patty-cake) to more than just this context, that you have taken it outside of Leisure Connections.

(Observation note, Session 3).

In this example, Nancy and Wade indicated that they had started to process meaning from their participation in the Pat-A-Cake exercise to outside of group and the PTSR program. Processing allowed group members to reflect on the meaning of their group experience; to generalize their learning experiences to outside situations.

On two occasions, during the interview, Sara referred to the use of processing by the RT in Leisure Connections. As she explained:

And in Play Shop we play, which I love. It’s easy for me to do. But, we don’t process it. Whereas in Leisure Connections, we’re not necessarily doing silly fun things that help you let off steam or reenergize or whatever. We did some playful things that were metaphors, but we also processed them and got insight (Interview with Sara).

Sara articulated how processing provided a framework for her learning experience:

I didn't feel that I learned as much in the actual Pat-A-Cake activity; whereas others had huge epiphanies. What I learned from was watching the processing and mostly watching the processing and integrating the information that I heard, and seeing, well, how does this apply to me?
(Interview with Sara)

The intervention processing was observed in all three session of Leisure Connections and discussed by the RT in interview. All participants referred to processing during the interviews.

Interpreting.

Interpreting involves offering "possible explanations for certain behaviours or symptoms" (Morran et al., 2004, p. 98). Interpreting occurred when the leader helped participants learn more about themselves; and promoted insight and meaning. The intervention was used by the Recreation Therapist, and offered participants the opportunity to learn more about themselves. Participants integrated group-related events and reflected on personal insights. The example below is from the interview with the Recreation Therapist:

Then I'll constantly connect what we're talking about in the present, how does this fit with things you're doing outside of here? So there's conscious attention paid to, here's what's happening in group. How does this happen outside here? Then bring it back to group, and bring it out to their life, and bring it back to group. So again it kind of creates a space for people to connect the dots. . . [A]round their whole life. 'Cause when they leave [the program], that's when they gotta apply all this stuff. To say it works really great in the context of a group, well that's wonderful, but once you leave that's not going to be helpful. You know? You have to be able see where it fits outside of there. (Interview with RT).

The Recreation Therapist's use of interpreting in Leisure Connections group provided a possible explanation about what leisure is and why the participant did not involve herself in leisure. Interpreting offered Nancy the opportunity to integrate new

learning about the benefits of incorporating healthy leisure into her lifestyle, as it relates to healing from trauma.

Interpreting was observed in all three sessions of Leisure Connections. The RT discussed the intervention interpreting, and one participant reflected on interpreting in the interview.

Self-Disclosing.

Self-disclosure occurs when the leader shares or reveals enough personal information allowing group members to gain a sense of their leader as a person. Leaders who share personal feelings, experiences, or here-and-now reactions to group members are self-disclosing. This intervention is also referred to as transparency. Sharing here-and-now reactions may be useful to help group members understand the group process (Morran et al., 2004).

The RT used self-disclosure; revealing personal awareness to group members' reaction to the rapid pace of her speech. The following example is from LC session #1.

As the RT described:

When one patient said something about speaking quickly, I wanted to acknowledge it as yes, that's what I do. And I didn't know I was speaking fast, so please feel free to tell me that. [...] I'm not going to do it perfectly. I have my own issues and one of them is that I speak quickly (Interview with RT).

During the interview, the RT acknowledged self-disclosure in reference to the group response about the concept of resistance to leisure. The RT stated:

I was surprised that the group, the entire group didn't at least acknowledge or connect to the idea of the resistance to leisure. That surprises me. I think that's the first group [not to respond] in all the time I've ever done it. (Interview with RT)

The intervention self-disclosing was observed in Leisure Connections sessions one and three, but not in session two. No participants referred to self-disclosing, but the RT discussed the intervention during the interview.

Feedback.

The intervention feedback is the sharing of one's own observations, reactions, thoughts and/or feelings of another. Positive feedback acts to reinforce appropriate member behaviours while corrective feedback from the leader may create anxiety in group members. The process of receiving feedback allows for group members to learn from one another and promotes reflective self-appraisal (Morran et al., 2004). The RT referred to her use of feedback in Leisure Connections session #2:

And I'm thinking of the minimizing one [theme] because that's actually come up several times where people will minimize, and then I'll give feedback and they will minimize and I'll stop and say, did anyone else just see what happened? (Interview with RT)

During the experiential exercise, Pat-A-Cake, the RT used positive feedback to support group members participation. The following example is from LC session #2:

The RT scans the grouped pairs, smiling and laughing from time to time. The activity continues on for approximately two minutes. As she asks group members to stop the Pat-A-Cake exercise, she is saying, beautiful, thank you, thank you. [...] The group members start the experiential exercise again. There is more laughter. The RT stands and smiles, she laughs and again says, beautiful, thank you, beautiful (Observation note, Session 2).

The RT used written feedback, which provided group members the opportunity for reflection. As Sara described:

I don't know if it was the RT, somebody wrote on my, I have kind of a question in my middle of three reflections. She wrote a little something. It asked me to think about, I can't remember, but whatever it was, I thought about it (Interview with Sara).

Feedback was observed in all three sessions of Leisure Connection. In the interviews, the RT reflected on feedback. Two of the participants commented on feedback during the interviews.

Table 2 summarizes the number of times in each session the Recreation Therapist used each group leader intervention. Throughout the process of data analysis and coding this researcher considered the interpretation of patterns within themes. Table 2 was created as part of analysis; data display. Drawing out was the most frequently used intervention across all three sessions. The RT used drawing out to generate early group discussion and involve all the group members during the initial stages of group. The RT prompted responses from group members with questions; to initiate involvement from and between the group members (energizing/involving). The RT continued to use drawing out to encourage group involvement in LC Session 2 and 3, possibly to increase the potential for group members to “openly exchange feedback or engage in other therapeutic interactions” (Morran, Stockton, & Whittingham, 2004, p. 95).

Table 2

Observed Group Leader Interventions by Session

Group Leader Interventions	Session 1	Session 2	Session 3
Protecting	10	1	0
Blocking	0	3	1
Supporting	3	5	2
Drawing out	17	16	14
Modeling	1	2	0
Linking	2	0	1
Processing	1	11	4
Interpreting	5	10	10
Self-Disclosing	3	0	1
Feedback	4	7	3

Table 3 summarizes the group leader interventions across all three sessions of Leisure Connections by program component used by the Recreation Therapist to facilitate group; check-in, psycho-educational, experiential exercise, and debrief of the session.

Table 3

Group Leader Interventions by Program Component

Group Leader Interventions	Check-in	Psycho-educational component	Experiential exercise	Debrief
Protecting	7	11	0	0
Blocking	1	0	2	1
Supporting	1	4	5	1
Drawing out	5	26	12	4
Modeling	0	1	2	0
Linking	1	2	3	0
Processing	2	2	3	3
Interpreting	5	9	3	2
Self-Disclosing	1	4	2	0
Feedback	4	4	4	1

Drawing out was the most frequently used group leader intervention across all group components of Leisure Connections. In addition, drawing out was the most frequent group leader intervention used during the psycho-educational component. Protecting and interpreting were the next most frequently used group leader interventions across the psycho-educational component. The following suggestions are made in response to this pattern. First, drawing out was used by the RT during the psycho-educational component as a means for group members' to respond to the white board activity. The white board activity was used with group members; some of whom may have found it difficult to share in the initial LC session. Drawing out was used throughout the psycho-educational activity as it enabled group members a choice of when to share;

offering an option to participate or pass. The psycho-educational component occurs in LC sessions 1 and 3.

Recreation Therapist's Actions

The Recreation Therapist utilized a range of therapeutic interventions and strategies to facilitate Leisure Connections. Specific actions were carried out by way of vocal changes, non-verbal gestures, leader's interaction style, and physical movement in the room. These actions were described as movement in the room, body language, vocal modulations and pausing, scans the room and makes eye contact, and creates a visual. These descriptions of the theme emerged during the analysis as the RT described her experience of the actions she used in LC and during the interviews as some participants described their experience of the RT's facilitation. The descriptions also emerged in response to the researcher's observations of the Recreation Therapist during LC. The Recreation Therapist was not asked directly to describe her perceptions and views of group facilitation; rather the actions as descriptions emerged in response to other questions during the interviews.

Movement in the Room.

The Recreation Therapist carried out actions by physically moving throughout the group room during facilitation of Leisure Connections sessions; walking to and from the whiteboard, writing on the board, moving closer to or away from group participants, and standing and sitting. As the Recreation Therapist articulated in her interview, the quotation below describes the significance of using movement in the room in her role as facilitator:

And I'll consistently move in front of the room so it doesn't seem to get very static where I'm staying in one place and it gets boring. But I'll be moving back and forth and forward, closer to them and back up to the board where I'm engaging people in what they're talking about doing (Interview with RT).

The Recreation Therapist's movement in the room was observed throughout all sessions and components of Leisure Connections. The following example was captured in the group discussion of the psycho-educational component as participants shared their core beliefs about healthy leisure pursuits resulting in healthy relationships:

The RT continues to prompt group members for their responses and she writes them on the board. She checks out with group members by asking a question and stops to ensure the group is on track – and again checks to reaffirm what a group member has just said. She goes back and forth to the board – points to words as emphasis for discussion that ensues – she moves in and back on her feet, closer to the group, away from the group as she draws out responses from members. The RT uses her body and her hands as she discusses and connects the work on the board to concepts and points made by her and brought up by group members (Observation note, Session 3).

Body Language.

Movement in various forms of body language was observed as the Recreation Therapist facilitated Leisure Connections group. Gestures such as nodding, turning her head toward group members, shifting and leaning in her chair, moving in closer to the group, are all noticeable actions carried out by the Recreation Therapist as a facilitation strategy to engage group members. In the following examples, varied descriptions of body language are depicted:

She turns and faces Wade, nodding her head. [...] She uses her hands as she discusses and connects the work on the board to concepts and points made by her and by group members (Observation note, Session 3).

In the example below, the Recreation Therapist had introduced the concept of negative self-talk and reenactments in leisure to group members. The focus of the discussion had centered on the concept of wearing a mask to cover up the true self, of not feeling happy in play, and experiencing resentments from choosing leisure activities so as to “not rock the boat”:

The RT moves forward in her chair and leans toward the group then poses the following statement for consideration to the group. What’s it like if I coped with my trauma through drugs and alcohol? There are things that people will do that keep them stuck in their trauma.
(Observation note, Session 1)

Vocal Modulations and Pausing.

During the facilitation of Leisure Connections the Recreation Therapist used a range of vocal modulations in response to her perceptions of group members needs in group; noticeable change in pace and volume, intentional use of a pause or silence to draw attention to, dramatize or emphasize significant learning moments. In the quotation below, the RT describes her use of vocal modulations during facilitation and the significance of using this strategy:

I know it slows down when I'm consciously wanting them to absorb a point. Like when she [Nancy] had her, ah-ha, like oh my god I made a choice for myself and this felt great, then I'll stop and give a dramatic pause on purpose, give her time to let it sink. And I'll say things like; do you hear what you're saying? I want it to be very clear, and I'll say it very slow, and then I want there to be silence while she lets it sink. And then it's usually in those moments that it becomes really, really tingly in there as people are all online with, holy geez, yeah, something really big is happening. I don't know what it is, but I can feel it. And she said, I don't have to think it I feel it. [...] And so I'll consciously be very clear when I speak. And I'll make it really; I'll enunciate and slow it down (Interview with RT).

Scans Room and Makes Eye Contact.

During the interview, the RT described her use of eye contact and scanning the room as a purposeful leader action used to communicate non-verbally during group facilitation. As described by the RT in the interview after LC session #2:

If something really big is going on and they're picking up on it and then I want to try to glance around like, are you hearing it? And I'm saying that to her but I'm also, I want to reverberate to everybody, are you hearing?
(Interview with RT)

Similarly, as described in the example below, scanning the room was highlighted as a way the RT responded to group members and received feedback about the direction of the group process:

Yeah, exactly. That's why I'm scanning the room as I'm saying it and as soon as I'm scanning I'm like, are you with me? Is everyone also? And some people may have more of a response than other people (Interview with RT).

During the interview, Sara acknowledged her experience of the RT's actions described as noticeable head and eye movements:

Nodding and going, uh-huh, uh-huh. Really honing in and holding eye contact. [...] Lots of eye contact, a bright open face, to summarize with really positive body language (Interview with Sara).

Similarly, Wade described his experience of the RT's actions; scans the room and makes eye contact in Leisure Connections as, **"She's focused right on you. She looks you right in the eye."** (Interview with Wade)

Creates a Visual.

The Recreation Therapist used physical movement, which created visual examples and representations, to describe, explain, and introduce concepts to group members during Leisure Connections. The visual examples were used to describe the introduction of the experiential exercises, and to explain verbal instructions with a visual

example for group members to follow. Reintroducing the visual later in the session prompted a reminder for group members of the concepts that the visual had previously created, for example, the basic hand clap pattern representing traumatic re-enactment.

In the following example from Leisure Connections session #2, the RT created a visual by modeling the basic hand pattern to introduce the experiential exercise Pat-A-Cake:

The RT says to the group, the basic clap is going to represent traumatic reenactment. She then does the clap motion of the patty-cake exercise. She continues by saying, and the clap will represent for you how you continue to create patterns in your life even when they hurt. As the RT is showing the clap motion, all group members watch her. She stands and asks the group to begin the patty-cake motion (Observation note, Session 2).

The RT created a visual representation for group members to make connections to the concepts of healthy leisure choices and lifestyle balance. This is depicted in the example below from Leisure Connections session #1:

[The RT] explains that an activity like jogging – if your connection to that choice is an emotional one – she offers an example by moving into a visual representation of intense running while standing – to describe how an activity choice can be connected to trauma; she explains during the visual representation how leisure can be connected to emotions, how it can be an unhealthy choice (Observation note, Session 1).

Table 4 summarizes the Recreation Therapist's actions used during Leisure Connections. The actions include physical movements and non-verbal gestures made in an attempt to engage group members and emphasize significant learning moments. The Recreation Therapist physically moved her body throughout the room; walking toward or away from group members, shifting her body toward or away from a group member(s), or moving to and from the board. As indicated in Table 4, two actions, movement in the room and scans the room and makes eye contact was used most frequently during the

intervention drawing out. In addition, vocal modulations and pausing was the other action most used during drawing out. Used infrequently was the action, creates a visual. This action was used in the psycho-educational component.

Table 4

Recreation Therapist's Actions by Group Leader Interventions

Recreation Therapist's Actions	Protecting	Blocking	Supporting	Drawing out	Modeling	Linking	Processing	Interpreting	Self-Disclosing	Feedback
Movement in room	1	0	2	18	1	0	6	6	0	1
Body language	0	1	2	8	1	1	1	5	0	0
Vocal modulations and pausing	1	2	0	11	1	1	2	6	3	1
Scans room and makes eye contact	0	1	4	18	1	1	6	5	0	2
Creates a visual	0	1	0	3	0	0	2	6	0	0

Recreation Therapist's Preparation and Reflections

The Recreation Therapist described her role as group leader and the processes involved in facilitating Leisure Connections. This description included the Recreation Therapist's decision-making, self-preparation and the reflective practitioner, and managing time constraints. These properties emerged during the analysis of the interview data as the RT described her experiences during LC sessions 1-3.

Recreation Therapist's Decision Making.

The RT described her awareness about the present block of Leisure Connections and the impact of the holiday on group members' first experiential exercise.

Because, we've only got the three sessions, and it's going to impact how people respond to the experiential exercise on Wednesday. If they don't have the experience of the experiential exercise on Monday, it changes how they experience it on Wednesday (Interview with RT).

Similarly, she articulated her decision to choose the Pat-A-Cake experiential exercise for session #2 due to the holiday and in part because of her assessment of the group participants:

I think first before group, I was conscious of what exercises I was going to choose because Monday was the holiday. I realized I tend to choose the one that I did, the patty cake, because it's the one that seems to be an exercise that people can readily see the parallels to. Versus the tug of war, which most people who are insight oriented tend to, if they're more concrete which a couple people in that group are, they tend to just see the exercise and not all of what it connects to. So I thought there would be less work given that we didn't have the experiential history before today (Interview with RT).

Self-Preparation and the Reflective Practitioner.

The Recreation Therapist's experience of facilitation is defined in part by her role as group leader. Her experience of this role includes logistical and personal preparation for Leisure Connections group; photocopying hand-outs, re-reading group notes and group member reflection cards, identifying her own level of readiness before group, and self-reflective practice about the group process. The RT described herself as a reflective practitioner; using mindful reflection to glean insight from previous group sessions and her experiences of facilitation. These self-reflections describe her own perceptions of the group process and facilitation experiences of Leisure Connections.

In the following quotation from the interview, the RT reflected on her process of preparing for group before each session of Leisure Connections:

Um, well I think the logistical preparations were done long before this group. In terms of, the group's been up and running for quite a number of years now. So I've been following a certain protocol, if you will that I designed years ago. For this group I prepared for it logistically again by photocopying things that I needed done, in terms of handouts, preparing your copies of the reflection notes. And I also briefly read over what we talked about so far in group. [...] So I'll always read through, just briefly glance to get a sense of who is working with what. I'll read the [group member] reflection notes as well (Interview with RT).

And later, she described her experience of self-preparation as it related to readiness for facilitating group and being grounded:

I find that on Mondays particularly where I teach fitness at lunch, I feel a little less prepared. Not logistically, but in terms of being grounded. And usually what I'll do, is when I get in, I try to be in group a few minutes earlier than everyone else, set up the chairs and just sit for a moment. Take a few deep breaths and allow myself to be right there so I'm ok, this is my next thing to do. And so often I'll come into group and do that. That's how I prepare (Interview with RT).

To the RT, the significance of reflective practice is expressed in her continued effort to implement change in Leisure Connections group. As she explained:

So I just created a sheet. I haven't used it yet, but as I said, in the last few weeks I've been looking at, as I'm constantly looking at, how can it be different. How can I change and how can I improve it. [...] Well, there's a whole bunch of things that I'm in the process of looking at how I could do differently (Interview with RT).

Managing Time Constraints.

The Recreation Therapist identified a number of time constraints, which she acknowledged during the facilitation of Leisure Connections; the researcher required time from the group, group started late, feeling rushed in group, and changes in the session time for group. During the interview, she described her experience of struggle with known time constraints in group session #1:

I was more aware, I guess, of the time factor because of the time changes with the group in terms of the group following after. I knew I wanted to be done by twenty [minutes] after to leave you [researcher] enough time to get done what you needed to get done. So just conscious of, not wanting to rush and put too much out too quickly (Interview with RT).

Due to the statutory holiday, Leisure Connections group involved three sessions instead of four. The RT acknowledged how this impacted her facilitation strategy for session #2:

[I]was conscious of what exercises I was going to choose because Monday was the holiday. I realized I tend to choose the one that I did, the Pat-A-Cake, because it's the one that seems to be an exercise that people can readily see the parallels to. [...] So I thought there would be less work given we didn't have the experiential history before today (Interview with RT).

Similarly, she described her awareness about time changes and constraints in Leisure Connections session #2: **"I was also really aware of getting started a little later today and knowing the experiential exercise takes the whole group and that there's this new time change of this group after."**

The RT elaborated on the impact that time constraints may have had on group members' experience of Leisure Connections session #3:

I think that I didn't spend as long actually reflecting on the experiential exercise. [...] I found myself well, aware of going, well, where is the time? I don't want this to feel rushed even though I was aware of it being rushed. [...] So, I tended to not process if you will, as much on experiential exercise. I had people kind of label what they noticed and then I found that what I did was sort of give a blanket explanation around some of the themes I was hearing. [...] [W]hat I have done in the past is have people talk more and more about their own experience. [...] That's when the big ah-ha moments come, you know they're talking about their own experience, of experiential exercise, elevate that to their larger life picture (Interview with RT).

Group Members' Experience of Therapeutic Alliance

In this study, therapeutic alliance is defined as a collaborative and mutually respectful relationship between the RT and the participant. Therapeutic alliance is characterized by concepts of trust, validation and empathic attunement (Haskell, 2003; Rivera, 1996). This theme, *Group Members' Experience of a Therapeutic Alliance* emerged during the analysis as all group members [participants] described their perceptions of a therapeutic alliance. Based on their participation in Leisure Connections, all participants experienced some level of interaction with the Recreation Therapist. Group members described concepts of a therapeutic alliance and expressed their group

experience to include aspects of validation, acknowledgement, empathy, trust, and safety. All group members described their thoughts and perceptions about the presence of a therapeutic alliance in direct relation to the Recreation Therapist's facilitation. Group members were not asked to describe their perceptions and views; rather these descriptions emerged in response to other questions during the interviews. In the following examples, through their rich descriptions, group members defined in their own words, the presence of a therapeutic alliance with the Recreation Therapist.

Group Members' Description of Therapeutic Alliance with RT.

Some participants highlighted a number of ways in which they perceived the Recreation Therapist as exhibiting understanding, acknowledgement, and individual support of their participation in group. Participants Tina and Brian did not participate in the interview process. Derek described his experience with the RT as facilitator of group:

She understands people more than, more so than any other normal person. Because she had me marked. Not marked, but she knew me through and through just by talking to me and playing patty cake. And I know what I'm like, and she's good. [...] By focusing on me when she was talking to me; as though we were the only two people there, yeah (Interview with Derek).

Wade agreed and shared a similar experience, adding:

She [RT] listens, and communicates well; encourages participation and encourages thought. Because when you talk, she listens. Just watch her, you just watch her. She's focused right on you. [...] She was able to hear, she's a very good listener, hear what I was saying and then, alright, and sort of, alright here, what about this? Very open, very open (Interview with Wade).

Similarly, Nancy described that, **"She [RT] encouraged me to get my feelings and thoughts across, and to talk openly and honestly about what was going on. And to participate in the exercise that was going on."** She later added, **"By listening to**

what I had to say. [...] She listened to me. And you could tell that she was very attentive to what I was saying.”

Sara articulated her experience of validation as it related to the RT as facilitator in group adding, **“I felt welcomed, and I felt that I belonged, and I felt that, I felt acknowledged and I felt validated. So I thought she may or may not know, but she’s doing the right thing.”**

Comfort and Safety in Group.

Some participants described experiencing a sense of comfort and safety in group while participating in Leisure Connections. The experience of a perceived mutual rapport and trust are elements of a therapeutic alliance. As Derek stated, **“I was very comfortable, my trust was there.”** Similarly, Wade offered, **“She never ever, she never made me feel uncomfortable. She encouraged participation. She didn’t try to take control.”** For Nancy, a perceived sense of safety in group helped her to make the connection between her fear and participation in leisure. As she articulated:

[I]t made us understand that if you have, if I go home, and I do leisure in my life, and I’m with trustworthy, safe people, then I can do leisure. Because if you’re with trustworthy, safe people, with good communication, there’s no reason to be fearful. [...] Yeah, safety. She [RT] kind of helped to set that, that tone of safety (Interview with Nancy).

Wade described experiencing safety to share in group and affirmation from the RT during the psycho-educational exercises. As he stated:

So every time you said something, it was important, it had meaning. You know, it’s not like, no, that’s the wrong answer. There’s no wrong answer. And that’s where that’s different. We’re used to wrong answers (Interview with Wade).

Sara agreed, stating a similar experience in group with the RT during Leisure Connections:

There's no right or wrong. [...] And even though that was not my exchange, she might have said, oh, I noticed you nodding, how's that playing out for you? (Interview with Sara)

For Sara, comfort and safety in the group was identified through the RT's use of facilitation techniques:

Nodding and going uh-huh, uh-huh. Really honing in and holding eye contact with that person, making validating statements, summarizing. I watch everybody and she did them (Interview with Sara).

Later, Sara added, **"Lots of eye contact, a bright face. [...] She didn't cut anybody off. And empathy, I don't know why I didn't say that first. Empathy, yeah, just acknowledging, validates. That's empathy."**

Derek described that accepting the RT as facilitator involved a shared level of comfort and safety among group members. As Derek expressed, **"They all kidded around. That is accepting. Otherwise, I would have heard negative talk after the session."**

Group Therapy Alliance Scale.

Subscale scores from an adapted version of the Group Therapy Alliance Scale (GTAS) (Marziali, Munroe-Blum & McCleary, 1997; Pinsof & Catherall, 1986) were examined (i.e., to categorize participant's similarity in responses) as an additional data source (triangulation) for comparing participants' perception of a therapeutic alliance and group cohesion in relation to their interview data.

Participants completed the GTAS (Marziali, Munroe-Blum & McCleary, 1997; Pinsof & Catherall, 1986) following sessions #1 and #3 of Leisure Connections. All participants rated statements which corresponded to their experience of a therapeutic alliance, a group therapeutic alliance, and group cohesion during Leisure Connections.

Participants responded on a 5-point Likert scale (5=strongly agree, 4=agree, 3=neutral, 2=disagree, 1=strongly disagree) to four subscale areas: group leader and individual participant (therapeutic alliance); group leader and the group (group therapeutic alliance); group members about the leader (group therapeutic alliance); and group members and participant (group cohesion). This researcher compared the participant's responses to items on the scale against their interview data.

As part of the larger research study, for the purpose of scoring, the subscales were categorized into four subscale areas: RT and individual participant, RT and the group, group members about the RT, and group members and (individual) participant. The focus of Section A is on therapeutic alliance (RT and individual participant). Both Section B and C focus on the group therapeutic alliance. The focus of section D (group members and the participant) is on group cohesion. Finally, overall satisfaction about the group is the focus of Section E. Each section is discussed in more detail in the following paragraphs.

Interpretation of Group Therapy Alliance Scale.

In Section A (therapeutic alliance), Nancy's response to question #21 "the group leader is helping me" was 5 (strongly agree), which may reflect her many insights in group especially during the Pat-A-Cake experiential exercise. As Nancy described:

I found that when she told you to change, like she told us to change without giving us any time to change, and then told us to change with like, ok I'm going to tell you to change, it made us understand that communication is awareness [...] That if I go home, and I do leisure in my life and I'm with trustworthy, safe people, then I can do leisure. Because, if you're with trustworthy, safe people with good communication, there's no reason to be fearful (Interview with Nancy).

In Section B (group therapeutic alliance), Derek's response to question #30 "the group leader does appreciate how important my relationships with some of the members of this group are to me" was 3 (neutral), which may reflect the challenges he experienced during the Pat-A-Cake exercise; changing the pattern to control his partner and being challenged by the RT. As Derek described:

Right off the bat, she knew people in general. And probably their habits, their habits of PTSD and what they go through and that showed us that she did have an understanding of what in fact we were going through. And if a person understands then it's easier to connect (Interview with Derek).

Nancy's response to question #17 "the group leader understands what all of the members want to get out of this group" was 5 (strongly agree), which may reflect her overall positive group experience.

In Section C (group therapeutic alliance), Sara's responses to the five subscale items were 3 (neutral) and 4 (agree), which indicated her perceived presence of a group therapeutic alliance. Sara described the RT in group:

She's very genuine. She's completely genuine; 'cause I felt a couple of times she was sharing her story so I got the sense that she's authentic. Who she is here is who she is out there. She's not wearing a mask or pretending to be an expert. The understanding part was validating, and the empathy was listening and reflecting back and saying, I've heard that before or, let me tell you how I've heard people, those times that there's silence (Interview with Sara).

Tina's responses to the items in Section C were 3 (neutral) and 4 (agree), which indicated her experience of a group therapeutic alliance from session #1 to session #3. Derek's responses to the subscale items (4=agree) did not change from session #1 to session #3. Nancy's response to question #8 "some of the other group members are in agreement with the group leader about goals for this group" was 2 (disagree), which may reflect her awareness that the RT did not state any concrete goals for LC group, nor did

she ask group members to disclose goals during the three sessions of group. Brian's responses indicated that he did not experience a group therapeutic alliance.

In Section D (group cohesion), Tina, Derek, Sara and Nancy's responses all indicated that they experienced the presence of group cohesion in Leisure Connections. Both Brian and Wade's response to question #25 "I trust all of the other clients in the group" indicated that they did not fully support the statement about experiencing group cohesion. Brian's score may reflect that he missed LC session #2 and was discharged from the *PTSR* before completion.

Group Cohesion

In Leisure Connections, group cohesion was experienced by participants. This theme emerged during the analysis as participants described their perception of being part of the group; and supported by other group members during Leisure Connections. This study adopted the definition of group cohesion as "the attractiveness of a group for its members" (Yalom & Leszcz, 2005, p. 55). As a cohesive group, members may experience a sense of comfort and belonging in group and feelings of support and acceptance by others in group. Some participants described their thoughts and perceptions about the presence of group cohesion with the RT, supporting the notion that therapeutic alliance is an aspect of group cohesion.

Group Members' Description of Group Cohesion.

During the interviews, some participants described their group experience as including a sense of connectedness and belonging to the group as a whole, and in relation to other group members. Two participants offered more specific examples, naming the

psycho-educational and experiential exercises as integral to their perception of group cohesion.

Nancy described her experience of feeling connected to the group:

I felt like, a belonging, like everybody was coming from the same place, even though we weren't. Some people were perfectionists at it, and I was like, but, we all came to the same understanding of what was going on.

Later, Nancy indicated the role the experiential exercise, Bean Bag Toss, in session #3 had on her experience of feeling connected to the group. As she described:

I felt like I was part of a group. Once when we were playing beanbag at the end, I felt more a part of the group than I did in the beginning. It felt a bit easier to get up and connect with the group because I had gotten to know these people a bit more. [...] Other group members helped me to feel included by them also participating. So, it didn't make me feel so isolated.

Similar to Nancy, Sara acknowledged the psycho-educational component of session #1 impacted her perception of group cohesion:

I felt good even on day one because I scanned, and I knew who was there. But, it probably became even more of a group when we were doing, well; I'm going to take it back. Day one, when we were brainstorming. That makes for me, makes a group because we're all sharing and there's nothing wrong, everything gets up there.

Sara described feeling “really good” about being part of the group. Specifically, she described her experience of group cohesion by saying:

I felt that we were individuals with our own particular taint on things, but that we brought all that together and worked as a group. I felt a group synergy and I also felt that we were also individuals too.

For Derek, he explained that being part of the group, “Felt good. It felt very good. [...] Well, actually, we're a very tight group.” Derek also described his group experience to include group connectedness between other group members and the RT: “Well, the group, I knew all the people and I trusted all the people, so I felt we're all

together. As an individual, when she [RT] talked to me, I focused on what she said and took it to heart.”

Nancy highlighted a significant interaction that was shared between group members and the RT:

She would give each individual a chance to talk and say how they felt, and she would ask, like, ok, you feel like that; is there any one else in the room who feels like that? And all of a sudden everybody’s hand would go up. So that you’re not alone in the way you feel.

As reflected in the following quotation, Wade described his perception of being in the group, being part of a team, and feeling connected:

I guess you feel part of the team. We’re all in this together. It’s funny, it’s even though you’re working on yourself, I think we’re all, you know, interested in the work everybody else is doing. [...] I was able to be myself and think about things as they related to me, which is individualistic, but it also is a group, because we’re all connected (Interview with Wade).

Recreation Therapist’s Description of Group Cohesion.

The RT described that group members were attentive and listening to each other in group. In the following quotation, the RT described in her own words, the presence of group cohesion in Leisure Connections session #1:

Well I noticed that this group, they seemed to be fairly attentive to each other right off the top. [...] I thought this group seemed more like, when people were talking, we got right to some traumatic beliefs, right off the top around enjoyment. [...] So, I was actually quite pleased that she started off that way; people really started getting into it right away. And it seemed like the whole group was listening when people were talking (Interview with RT).

The RT described Leisure Connections session #1 as including a sense of cohesion by stating, **“They did seem to gel. I think, I guess what I’m saying is I’m encouraged by how people were listening and attentive today, that they’ll gel more as we go.”**

In Leisure Connections session #2, the RT referred to processing the experiential exercise, Pat-A-Cake, as a shared group experience:

And everybody was right with me and I could feel that kind of energy coalesce into one stream, and I thought, oh good, good, good; we're all tapped into this idea, and they're right there with them. 'Cause it's really important not only for her, but for everyone else (Interview with RT).

As the interview progressed, the RT continued to describe her awareness of group members' during Leisure Connections session #1:

I guess what I'm saying is I'm encouraged by how people were listening and attentive today, that they'll gel more as we go. [...] Like, almost, you know, to see them starting to gel already. I felt encouraged that the group might gel more as we went along, [...] This group seems a little closer from the get-go than the last group. So I think that the feeling that I had was a little bit more relaxed. And maybe that was also part because I knew you were there. So maybe there is obviously that piece and I'm going, oh good they're gelling right off the top. I feel like they're gelling fairly well (Interview with RT).

Suggestions for Changes to Leisure Connections.

All group members commented on some aspect of the RT's facilitation of Leisure Connections. Some group members articulated their belief of competency in the facilitator, while others described recommendations for facilitator improvements or changes to the group; length, mandatory versus self-referred, re-scheduling for holidays. As Derek stated in his view about what areas the RT might improve on as facilitator, **"[t]here aren't any. No. She [RT] might want to slow down when she speaks but that's about it."** Sara agreed with a similar response adding, **"I just wish that the RT would not speak so quickly sometimes. [...] Just to ask herself or check back with herself from time to time, just slow down. You know what, it's almost like she wasn't breathing."** This concept was also articulated by Wade, **"[o]ther than at times she's got too much in there, she expresses it too fast. She's got so much knowledge**

and it just zooms [...] and it was brought to our attention when we were there too, hey slow down. And you know she did.” Wade also offered his perspective about changes to Leisure Connections by stating, **“Change nothing. When I thought of something that wouldn’t be in [LC group], you know without knowing anything, I think Leisure Connections is far more powerful than it seems.”**

Nancy elaborated on Wade’s statement by stating:

I think everything the RT did was helpful to me. She ran the group great. She's an awesome group leader. And she made you understand all of what was going on, what the patty cake game was all about. And how you felt, she brought out your feelings, your thoughts and feelings.

Sara described frustration about missing one group session due to the holiday schedule and summarized her group experience by saying:

Well this isn't about Leisure Connections, this is about if a holiday comes up. I wish that we would make time, a re-scheduled time. [...] And I would have liked to have not lost that day. [...] The ongoing ones you think, well, what's one or two if you're having sickness or whatever. But when there's only four if you lose one [group] you lose a lot (Interview with Sara).

Nancy agreed and added her recommendations for Leisure Connections; stating frustration about three versus four group sessions:

I think everything in this program; it's probably one of the best programs in the place. Keep everything, especially the RT. Well I only had three classes. I think it should be a little bit longer, it's supposed to be four. Yeah, it's you know, I don't know what I could add because I don't have any experience with leisure.

Prior Influences and Assumptions about the RT

Participants’ experiences in group may have been shaped by: (1) prior interactions with other participants in their block of Leisure Connections; (2) the reputation of Leisure Connections conveyed through conversations with people who previously attended LC;

and (3) participants' prior interactions with the Recreation Therapist when she facilitated other groups and attended community meetings within the PTSR.

Participants' experiences with Leisure Connections were affected by prior interactions with other participants in their block of Leisure Connections. In the following example, Derek noted his relationship with group members from the larger community by stating, **"oh yeah, I knew them all. [...] Well I'm going on my seventh week. And I know all the people, we're always kidding around."**

The reputation of Leisure Connections was conveyed to participants during previous conversations with peers who had previously attended LC. Later in the interview, Derek reflected on a conversation with his peers:

Before I went to Leisure Connections, and I was talking to some people about going to Leisure Connections, and I said, have you been there? And they said, yeah, and they recommended it. You know; go go its great. It changed me. And I was thinking, yeah, right. [...] And they said it's the best thing (Interview with Derek).

Sara described a similar encounter with peers:

Oh right, and the talk amongst my peers, who maybe hadn't met her [RT] before. Some may have had her in process group but some might have not known her at all, they just really loved the class. Um-hm. Very, very, she's [...] people really like her. And it's interesting, when you don't know and you say, what's Leisure Connections like? People will clam up and they say, I'm not telling you because it will wreck it. It's magnificent but I don't want to tell you because it will wreck it. [...] But the talk is oh, I'm not going to tell you because it will wreck it, but it's amazing. That's the talk (Interview with Sara).

Nancy, described comments from her peers about their experience of Leisure Connections group by stating, **"The group is bragged about before we even enter. That everybody loved it."**

Participants' experiences of Leisure Connections were also influenced by their prior interactions with the Recreation Therapist when she facilitated other groups and attended community meetings within the PTSR. Sara acknowledged her prior experience of the RT and how this may have influenced her subsequent experience in Leisure Connections:

I find that she [RT], I had her as a substitute one day in art therapy, and I find that she is amazing at making links. And I don't know if this is the place for it, but also her style, which is, that's something I've heard from other clients. [...] So, I was able to just go with it, cause I thought I'm in really good hands here (Interview with Sara).

Sara elaborated on this concept as it related to her experience in Leisure

Connections:

I went into, sometimes when you go into group you've never had that facilitator before. I went in with really good vibes for her because I had had her as a sub in the art therapy where she was amazing. And so I was really looking forward to getting to more time with her (Interview with Sara).

Similarly, Derek added that he had experienced the RT as facilitator in a previous group, Play Shop, stating, and **"I had seen the RT a couple of times at Play Shop."**

Wade also acknowledged participation in Play Shop and added the statement, **"Play, uh play, what do you call it? Play Zone, Play Shop? It's hard for me to understand people that have difficulty playing. You know and getting different perspectives on you know different people, and why they don't or do [play]."**

Similarly, the Recreation Therapist acknowledged recognizing and/or knowing participants from her regular attendance at two PTSR community meetings, her role as team member in the PTSR program, as a co-facilitator in process group, or acting as a substitute for other groups within the larger program. As the Recreation Therapist stated:

And that's also because I know him from other groups that he's also very avoidant emotionally. So I thought, I wonder if that's what he's doing so it's not just in this group experience. I drew on that from the morning group as well (Interview with RT).

Summary

The findings presented in Chapter Five provide a response to the research questions and case study questions. Research question 1, (What does the Recreation Therapist do to facilitate Leisure Connections?) was answered in the sections titled, *Group Leader Interventions*, *Recreation Therapist's Actions*, and *Recreation Therapist's Preparations and Reflections* (Figure 3). *Recreation Therapist's Actions* responded to case study question 1, (What actions are being carried out by the Recreation Therapist?). In addition, *Group Leader Interventions* responded to case study question 1b, (What group leader interventions are used by the Recreation Therapist?) The summary of findings is depicted below in Figure 3.

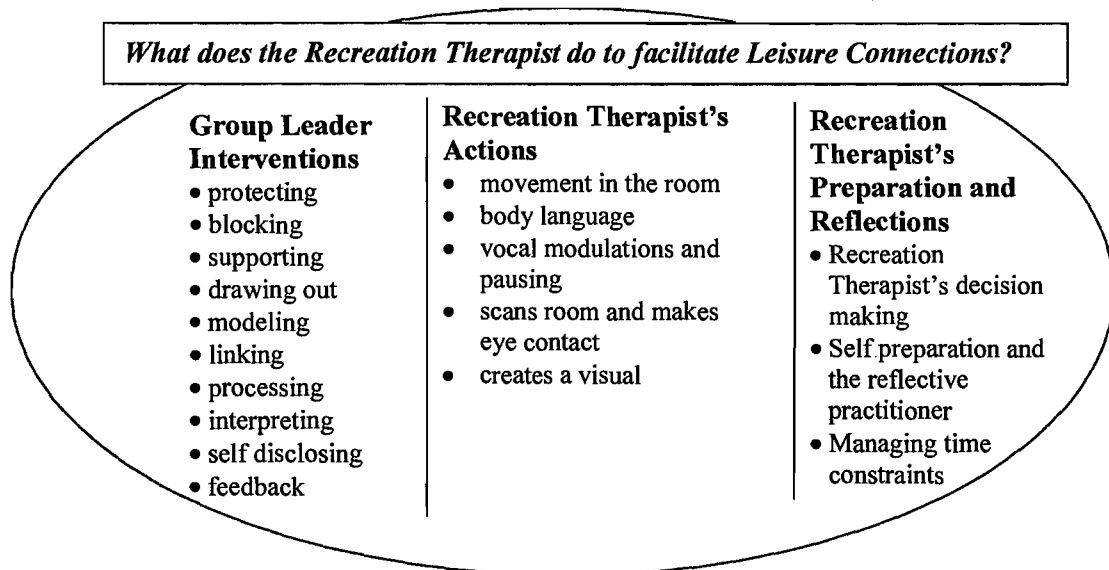


Figure 3. What does the Recreation Therapist do to facilitate Leisure Connections?

Research question 2 (How is the facilitation experienced by group members?) was answered in sections titled *Group Members' Experience of Therapeutic Alliance* and

Group Cohesion (Figure 4). *Group Members' Experience of Therapeutic Alliance* and *Group members' Description of Group Cohesion* responded to case study question 2 (What is the interaction between the participants and the Recreation Therapist?). In relation to this case study question, the recreation therapist's remarks about the interaction were described in *Recreation Therapist's Description of Group Cohesion*.

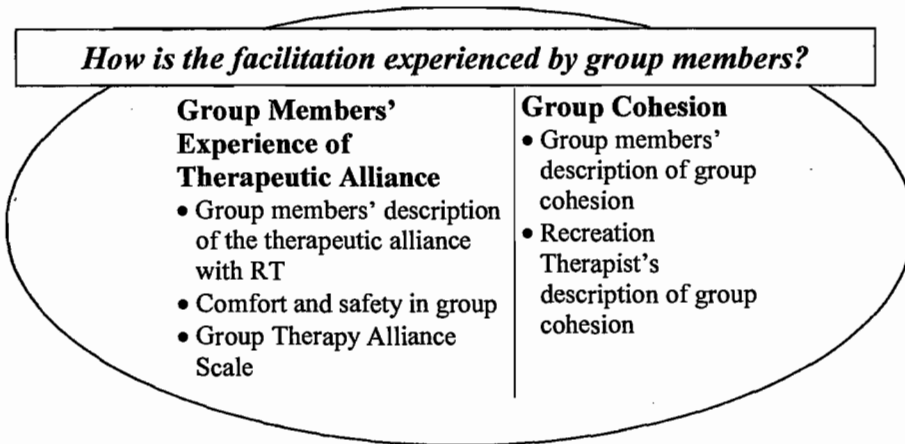


Figure 4. How is the facilitation experienced by group members?

In addition, *Group Member's Description of Group Cohesion* and the *Group Therapy Alliance Scale* responded to case study question 3 (What are the noticeable reactions and changes in the participants? (Figure 5)

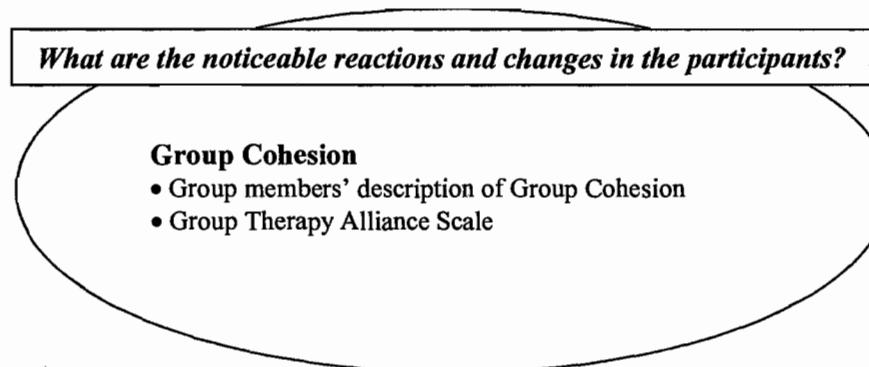


Figure 5. What are the noticeable reactions and changes in the participants?

In Chapter 6 connections are made to the literature pertaining to each theme and patterns are discussed. Following this, a revised conceptual framework is presented which

depicts the relationship between facilitation techniques, the experiences of facilitation, and therapeutic alliance and group cohesion within the context of the *Program for Traumatic Stress Recovery (PTSR)*.

Chapter Six: Discussion and Conclusions

The purpose of this final chapter is to present a discussion of the findings. The chapter begins with a discussion of the group leader interventions used in the three Leisure Connections (LC) sessions. The implications of the findings in relation to the study propositions and the revised conceptual framework will also be addressed. Implications of the study for clinical practice are described in the context of the development of a program manual for Leisure Connections. The chapter concludes with the strengths and limitations of the current study and provides recommendations for future research. In response to the first research question—What does the RT do to facilitate Leisure Connections?—the facilitation techniques used in each session will be discussed in more depth in relation to the literature on group development. Following this, group therapeutic alliance and group cohesion within Leisure Connections will be discussed. This chapter will also present a revised conceptual framework of the relationship between the Recreation Therapist's (RT) facilitation of a psycho-educational leisure-based group for survivors of trauma and the facilitation as it was experienced by the group members. This chapter will place the revised conceptual framework in the context of prior research to expand the understanding of facilitation techniques used with survivors of trauma.

Group Leader Interventions in Session 1

Session 1 consisted of a check-in, a psycho-educational component, and a short debrief. In Session 1, check-in consisted of the RT introducing herself and the researcher, explaining that she [RT] did not know who was participating in the research and

emphasizing that her role was to facilitate LC. To help group members become more comfortable and promote a sense of safety, the RT outlined the group process and discussed group guidelines (closed group), and introduced Leisure Connections (e.g., topics, number of sessions). During check-in, protecting was used most frequently by the RT. As Morran et al. (2004) describe, protecting is one of three interventions (others include blocking and supporting) that are categorized under “protecting group members/promoting safety” (p. 92), useful in creating a climate of trust, openness and cohesion in the group. This was important for promoting a sense of safety during the initial stage of group development and ensured that group members did not share too much information or disclose too quickly (Morran, Stockton, & Whittingham, 2004).

The psycho-educational component in Session 1 began with an icebreaker activity and structured conversation introducing leisure and the various ways of understanding leisure choices; use of free time, enjoyment, and motivations for engaging in leisure. During the psycho-educational component protecting continued to be used, and in addition drawing out, interpreting and feedback were also used. As Morran et al. (2004) describe drawing out, interpreting and feedback are “used to stimulate forward progress, increase member participation, and enhance interpersonal learning” (p. 92). As Magen and Mangiardi (2005) note, during early stages of group development “group leaders need to be active, to avoid long periods of silence, and to support the creation of an atmosphere of safety and curiosity” (p. 357). Trotzer (2006) refers to the intervention drawing out as questioning, stating that “the skill of questioning is still an important and highly relied on tool in the group process” (p. 190). Drawing on Clarke (1989), Trotzer (2006) describes five qualities of effective questioning categorized as the following:

supportive (allow the respondent latitude to reflect and respond); relevant (relate to the immediate experience of the group member and lead to productive discussion); regulated (frequency and timing are critical and in the control of the group leader); expansive (enable or facilitate member expressiveness) and; open-ended (prompt members to generate material and expand expressiveness). According to Trotzer (2006), questions can be used “to help group members consider aspects of themselves and their concerns they haven’t thought of before” (p. 191). The findings of the current study indicate in Session 1 how the RT used questions in the form of an ice breaker activity as a way to draw out responses from participants while incorporating the leisure components of activity, enjoyment and choice. The use of questions allowed the participants’ to consider leisure and its components.

During the psycho-education component the RT was able to work with the group members’ statements. Interpreting is “often used to introduce and teach theory to group members, a factor that is very helpful in providing a conceptual base to the work a leader does in groups” (Trotzer, 2006, p. 186). In this session the RT was providing group members with a foundation for understanding leisure as an activity, as a state of mind, and in relation to intrinsic or extrinsically motivated choices. As Trotzer (2006) describes, interpreting is an interaction skill which enables the leader to control or guide group interaction and relate the material (the white-board activity) to the situation being discussed (healthy leisure choices and traumatic reenactment in leisure).

During the psycho-educational component, feedback consisted of acknowledging a participant’s statement and/or writing it on the white-board. According to Morran et al. (2004) feedback includes, “the sharing of one’s own observations or reactions regarding

the behaviour, thoughts, or feelings of another” (p. 99). They note that this is an appropriate intervention at any group stage. In Session 1 the RT used feedback at the first of two levels described by Morran et al. (2004), whereby the leader “gives and receives feedback within the group” (p. 100). The RT also used feedback, in the form of an icebreaker activity, asking participants to choose and respond to one of five statements about leisure. As Morran et al. (2004) describe structured activities, the psycho-education component, provides a format for feedback exchange and “[t]hese types of planned exercises are designed as ‘ice-breakers’ that can lead to more naturally occurring member-to-member feedback in future sessions” (p. 100).

The RT did not finish the psycho-educational component of Session 1. The RT noticed that she was running out of time in the session. The RT used the interventions supporting and processing in debrief. Here, she wrapped up the group by thanking group members for participating (supporting), asking them to reflect on the group and stating if “something comes up from group” to take it to other groups (processing).

Drawing on Frey, De-Lucia-Waack and Kaladner (2005) define group facilitation as “any meeting technique, procedure, or practice that makes it easier for groups to interact and/or to accomplish their goals” (p. 486). Throughout the sessions of Leisure Connections the various *RT Actions* (scans room and makes eye contact, creates a visual etceteras) can be understood as general factors used by the RT that facilitate the group. As Morran, Stockton and Whittingham (2004) indicate, specific leader behaviours impact the group and its members. They state that “group dynamics and outcomes are influenced by general factors such as the leader’s interaction style, personal characteristics and attitudes” (p. 91). The findings from the interviews indicate the importance of the use of

RT Actions (scans room and makes eye contact, creates a visual etceteras) to facilitate Leisure Connections. For example, the RT describes the use of actions to include participants in the discussion (scans room and makes eye contact) and to introduce the experiential exercise Pat-A-Cake (creates a visual). In the current study, during the interviews, some participants describe noticeable head and eye movements as RT Actions (scans the room and makes eye contact).

Group Leader Interventions in Session 2

As Magen and Mangiardi (2005) describe group development, “each successive stage places unique demands on the group leader and offers differing opportunities for the group at large” (p. 357). As the findings of the current study indicate, during check-in of Session 2, the RT asked if anyone had anything to share from the previous session (drawing out). In response to the participants’ statements, the RT used processing and interpreting. Processing was used to help participants “reflect on the meaning of their experience; [and] better understand their own thoughts, feelings and actions” (Morran, Stockton & Whittingham, 2004, p. 97). Feedback was the intervention most frequently used by the RT during check-in; when group members shared insights from last week the RT provided feedback around their awareness. When Wade spoke about perfection in [his] leisure activity, the RT used interpreting. Corey notes that interpreting is used to “offer possible explanations for certain behaviours or symptoms” (as cited in Morran, Stockton & Whittingham, 2004, p. 98). In response to Wade, the RT commented on the changes in his thoughts and behaviours around perfection in leisure, a common pattern among trauma survivors (Griffin, 2005). As Morran, Stockton & Whittingham (2004) describe, “leaders must have an understanding of members’ deeper-level feelings,

patterns of behaviour, and motivations” (p. 98). Blocking, also known as cutting off or intervening, is “a specific type of protection used to stop a group member from story-telling, rambling or otherwise talking in a manner that runs counter to the purposes of the group” (p. 94). To intervene and stop some participants from continuing to converse, the RT used blocking to move into the next part of the group.

Session 2 included the experiential component, Pat-A-Cake. As Gass (1993) describes, experiential learning is “learning by doing combined with reflection” (p. 4). As the experiential exercise began, the RT made a Pat-A-Cake motion and asked the participants to do the same (modeling). As the exercise continued the RT used drawing out a number of times to ask participants to pay attention to what they noticed (i.e., stating, “what do you notice, what else do you notice”). Feedback was used during the experiential exercise and the RT also used supporting (i.e., stating, “good, good, keep going”) to encourage participation. Morran et al. (2004) note that supporting is “designed to directly reassure members and thus encourage and reinforce their appropriate participation” (p.94). According to Gass (1993), experiential activities create challenge, discomfort and a need to problem solve. Therefore the RT used supporting because the exercise was potentially uncomfortable for participants. Further, Morran et al. (2004) state that “the leader may choose to directly support the members’ effort to reveal scary feelings or sensitive information to the group” (p. 95). After several cycles of the Pat-A-Cake exercise the group reformed a circle at the request of the RT and she continued drawing out and processing participants’ experience by asking a number of questions (What did you notice? What was it like for you? How do you feel?). In using the interventions drawing out and processing during the experiential exercise, the RT

increased the likelihood of participants' focusing on and becoming aware of their behaviour, the decision-making around their behaviour, and the connection between specific behaviour and their wants and needs. The use of drawing out and processing increased the participants' potential learning as it focused on here and now behaviours in the experiential exercise. As Shank and Coyle (2002) describe, processing within therapeutic recreation practice "focuses on here and now behaviours evident in activities" (p. 219). More specifically, processing helps participants to make connections between thoughts, feelings and behaviours and consolidate learning from activities (Shank & Coyle, 2002).

The RT continued to use the interventions drawing out and processing during debrief of the session. In addition, interpreting was used by the RT to connect the participants' thoughts and experiences from the Pat-A-Cake exercise to identifying old habits and re-enactments, comfort with and initiating change and communication (i.e., the RT stating, "do you mean for you to be in control – meaning you make the changes?"). The RT also connected the experiential exercise to the message that if they continued to practice changing their old patterns, the [new] behaviour would become familiar. As Trotzer (2006) described, interpreting "promotes member insight and assists meaning attribution" (p. 186). The use of interpreting during debrief of the experiential exercise Pat-A-Cake provided participants the opportunity to recognize some of their unhealthy patterns of behaviour. As described by Morran, Stockton and Whittingham (2004), "Insight... may be difficult for the member to acquire without some cognitive framework being provided by the leader" (p. 98).

Group Leader Interventions in Session 3

During check-in, drawing out and interpreting were the most frequently used RT interventions. During this session, feedback, supporting, and processing were also used. Linking was the only intervention used that differed from Sessions 1 or 2. Linking is described as an intervention used to “connect what one group member is saying or doing with the concerns of one or more other members thereby encouraging interaction among group members and promoting the development of facilitative relationships” (Morran, Stockton and Whittingham, 2004, p. 96). During check-in the RT posed questions, which enabled participants to hear and respond to each other. When all participants raised their hands in response to the RT’s questions, they were able to see that they shared a similar response.

In Session 3, the psycho-educational component focused on the concepts of healthy leisure choices, and creating a healthy history. Drawing out and interpreting were the interventions used most frequently by the RT. The RT used drawing out to ask participants about healthy leisure choices that they had been making while in the PTSR, and captured their responses using the white-board (went for a walk, coffee with a friend). She then used interpreting to connect their responses from these current experiences to illustrate how to create a healthy history by continuing those changes over time (i.e., stating, “What [word] could you see it turning into over time, if done on a regular basis”). Again, interpreting was used by the RT for meaning attribution and to connect participants’ experiences to a cognitive framework (i.e., creating a healthy history). As the participants responded to drawing out, the RT listed their responses on the white-board. She then asked them to reflect on how they felt in response to the list

(processing). In using processing, the RT helped the participants' to express their feelings (hopeful, sad, scared) in response to the words that had been written on the white board. This is an important intervention. As DeLucia-Waack & Kalodner (2005) state, "[t]he most common mistakes group leaders make is not to process an activity. Simply experiencing events in group is not sufficient for growth but must be augmented by processing to provide a framework for retaining, integrating and generalizing the experience" (p. 79).

The experiential component in Session 3 consisted of a bean bag toss. This experiential activity was described by the RT as an exercise in mindfulness. The RT participated in this activity. After the experiential exercise, the RT used drawing out by asking participants to share a response to the question, "What do you notice now"? The processing of participants responses included scared, tense, focused, and quiet. As the RT drew the experiential activity to a close she made a connection between the bean bag exercise and being focused on the present moment, with the exercise symbolizing the power of the past and its hold on the present. The RT concluded with the statement, "How much power does the past hold over the present"? Sara shared with the group her awareness of being preoccupied with what others think about her and the RT used blocking to intervene and stop the conversation. The use of blocking in this situation was also due to time constraints.

During the debrief, the RT used drawing out when she handed the reflection cards from Sessions 1 and 2 back to the participants and asked them to share their observations. Processing occurred when the RT connected participants' felt observations about their reflection cards to the psycho-educational component that occurred earlier in the session

(healthy leisure experiences). For example, as Sara commented on her reflection card she noted “being different.” The RT used interpreting to respond; making a statement about holding on to old beliefs about self.

Summary of Sessions 1-3

In summary, the group leader interventions used by the Recreation Therapist across all three sessions of Leisure Connections are listed below in descending order of frequency and include: drawing out, interpreting, processing, feedback, protecting supporting, blocking, self-disclosing, linking and modeling (see Table 2). The patterns of group leader interventions used by the RT are consistent with the literature that explains group development and the use of interventions most therapeutic in the initial/beginning, middle/working, and into the end phases and stages of group (Magen & Mangiardi, 2005; Morran et al., 2004). As indicated earlier in this study (see Chapter Three) the group leader interventions were selected to guide this researcher during data collection and throughout the analysis process. The overall pattern of use of the group leader interventions used by the Recreation Therapist in this study represents a small sample of the many possibilities of interventions for use with groups (Morran et al., 2004).

The group leader intervention drawing out was the most frequently used intervention across all three sessions of Leisure Connections (see Table 2). This finding is supported by Morran et al. (2004) and Trotzer (2006). The authors reported that group leaders’ use the intervention drawing out and questioning to generate early group discussion and involve all group members in the initial stages of group. The findings from this study suggested that the RT used drawing out to prompt responses from group members with the use of questions; to initiate involvement from and between the group

members (energizing/involving). In session 1 the primary program component used was psycho-educational. The RT did not complete the component due to time constraints, and therefore group members' experienced less opportunity for depth of processing; learning from the white board activity.

The RT continued to use drawing out to encourage group involvement in LC Session 2 and 3 (see Table 2) as a way to increase the potential for group members to "openly exchange feedback or engage in other therapeutic interactions" (Morran et al., 2004, p. 95). This was indicated in group members' participation in the experiential exercises and debrief. In session 2 the primary component used was the experiential exercise, Pat-A-Cake. During the experiential exercise the RT used drawing out most frequently (see Table 3). The intervention processing was the next most frequently used intervention in session 2. Overall, processing was used most frequently during the experiential components of Leisure Connections (sessions 2 and 3). Shank & Coyle (2002) describe processing as a therapeutic technique used within therapeutic recreation practice to help participants make connections and consolidate learning from activities. In Leisure Connections the RT used experiential exercises to process issues of trauma.

In session 3 the experiential exercise, Bean Bag Toss was cut short due to time constraints. By using experiential components in Leisure Connections the RT likely increased group members' potential learning of in-the-moment awareness, although due to time constraints there was limited opportunity for in-depth processing of learning. The RT used the skill of questioning and drawing out effectively to facilitate during all three sessions of Leisure Connections. This was described in the findings (Chapter Five).

Recreation Therapist's Actions

The ten group leader interventions described earlier in this section are primarily verbal in nature (e.g., drawing out, processing, interpreting, and linking). However, as Morran et al. (2004) describe, group dynamics may be influenced by more general factors such as “the leader’s interaction style, personal characteristics and attitudes” (p. 91). These were reflected in the *RT Actions* described in Chapter Five (see Table 4). The findings from this study indicated that the RT used a range of facilitation techniques; group leader interventions in response to specific actions. The actions include physical movements and non-verbal gestures made to engage group members and emphasize learning moments. The Recreation Therapist moved throughout the room; walking toward or away from group members, shifting her body toward or away from a group member(s), or moving to and from the board. As indicated in Table 4, two actions, movement in the room and scans the room and makes eye contact was used most frequently during the intervention drawing out. The group leader interventions were supported by the RT’s use of actions; vocal modulations and pausing to emphasize a point, a non-verbal gesture, and action oriented cues (body movements). As will be discussed in the following section, these *RT Actions* helped to foster therapeutic alliance and group cohesion. The connection between the *RT Actions* and *Therapeutic Alliance* and *Group Cohesion* was described previously in Chapter Five in the words of the participants and the RT. This will be further explored in the following section.

Group Member's Experience of the Facilitation

In response to the second research question—How is the facilitation experienced by the group members?—themes were introduced in Chapter Five and described as *Group Members' Experience of Therapeutic Alliance* and *Group Cohesion*.

Therapeutic Alliance

As discussed in Chapter Five, participant's responses to the Group Therapy Alliance Scale subscale items were compared against their interview data describing their experiences of a therapeutic alliance in Leisure Connections at Session 1 and 3. These findings were consistent with Proposition 2—Individual group members may experience the presence of a therapeutic alliance between themselves and the Recreation Therapist. The *Group Members' Experience of Therapeutic Alliance* was described and includes *Group Members' Description of the Therapeutic Alliance with RT* and *Comfort and Safety in Group*.

In the process of a therapeutic relationship, an emotional investment is entered into by both the facilitator and client. This interpersonal connection forms a therapeutic alliance that is structured within the facilitator/client dyad (Corey, 1996; Rivera, 1996). As described in Chapter Five this emotional connection was present in the RT's interactions with the participants. Other authors describe a collaborative and mutual engagement, and empathic attunement between the therapist and the client as central to the therapeutic alliance (Haskell, 2003; Rivera, 1996).

Participants described characteristics such as: trust, safety, empowerment, and validation. Participants' described their feelings of safety; being heard, not judged by the RT or peers; and their perception that the RT understood PTSD and survivors of trauma.

As suggested by some authors, trust and safety are integral in establishing a therapeutic alliance, and a key factor in enhanced treatment outcomes (Haskell, 2003; Herman, 1992; Pearlman & Courtois, 2005; Rivera, 1996).

Group Cohesion

Leisure Connections provided a social environment for interactions and supportive relationships. These relationships were fostered between group members and with the RT. The theme of *Group Cohesion* is consistent with Proposition 3—Group cohesion may be influenced by the presence and experience of a therapeutic alliance during the facilitation of Leisure Connections. As stated by Yalom & Leszcz (2005), members of a cohesive group, “feel warmth and comfort in the group and a sense of belongingness; they value the group and feel valued, accepted and supported by others (p. 55).

This study uses the broad definition of group cohesion as “the result of all the forces acting on all the members such that they remain in the group, or more simply, the attractiveness of a group for its members” (Yalom & Leszcz, 2005, p. 55). The data suggests interdependence between therapeutic alliance and group cohesion, which is explained in the next section. This is supported in the literature (DeLuccia-Waack, 2004; Marziali, Munroe-Blum & McCleary, 1997; Shank & Coyle, 2002; Yalom & Leszcz, 2005).

RT's Facilitation of Leisure Connections, Therapeutic Alliance and Group Cohesion

The findings describe the ways in which the Recreation Therapist's facilitation of Leisure Connections contributed to the experience of a therapeutic alliance and impacted

group cohesion; that is, the findings support the second half of proposition 1. In therapeutic recreation practice, Shank & Coyle (2002), make the connection between group leader interventions and group cohesion. They describe that “[p]rocessing increases the likelihood that clients will benefit from TR interventions by not allowing the conclusion of the activity to be the end of the learning experience” and promotes group cohesion (p. 219). The RT’s facilitation of LC using experiential exercises [see Session 2] to process trauma issues helped to foster therapeutic alliance and group cohesion. During the facilitation of the experiential exercises participants’ described their experiences of “in-the-moment” awareness and identified a discrepancy in feelings. Authors such as Griffin (2005), Haskell (2003), and Herman (1992) discuss trauma and the significance of survivors processing in-the-moment connections to their feeling states for healing. As described in Chapter Two, some of the key factors that characterize a therapeutic alliance are described as: containment, collaboration, mutuality, validation and empathic attunement; all which lead to empowering clients to make change (Haskell, 2003; Rivera, 1996). As indicated in the data, the Recreation Therapist’s use of group leader interventions and actions contributed to these elements (see Table 4).

Program for Traumatic Stress Recovery (PTSR)

Survivors of trauma often struggle with issues of trust and interpersonal safety (Herman, 1992). Trauma challenges the development of therapeutic relationships because it may disrupt the “basic human capacities of trust, autonomy, initiative, competence, identity, and intimacy” (Wright, Woo, Muller, Fernandes, & Kraftcheck, 2002, p. 395). In the original conceptual framework presented in Chapter 3, it was assumed that the therapeutic community encompassed in the *Program for Traumatic Stress Recovery*

(PTSR) would influence the participants' experience of a therapeutic alliance and group cohesion. Proposition 4—an assumption exists that the larger therapeutic community (PTSR) may impact and/or contribute to the participants' experience of a perceived therapeutic alliance and group cohesion in Leisure Connections—presumed influences such as other program staff and patients. The findings however revealed that the therapeutic community had a greater than anticipated impact in creating an essential foundation prior to patients entering Leisure Connections. The community milieu and foundation of safety were central to the formation of trusting interpersonal relationships and supported group members' experiences of facilitation. Bloom's (1994; 2000) sanctuary model incorporates what Haigh (as cited in Bloom, 2000) described as the five ingredients of a therapeutic environment including attachment (a culture of belonging), containment (culture of safety), communication (culture of openness), and involvement (culture of participation and citizenship, and agency (culture of empowerment). The social context provided by the therapeutic community and a shared history of trauma influenced the participants' perceived presence of a therapeutic alliance and group cohesion. As indicated in Chapter Five in *Prior Influences and Assumptions* about the RT, the therapeutic alliance was relatively high at the beginning of Leisure Connections. This was likely due to the influence of the therapeutic community (PTSR) on the participants' experience in Leisure Connections. As Wright & Woo (2000) describe, the PTSR is delivered “almost exclusively by means of a group modality [which] enhances the experience of community” (p. 37). This finding is consistent with what Yalom & Leszcz (2005) describe as the concept of Universality. As defined by Yalom & Leszcz, universality refers to the group members' experience of “hearing other members disclose

concerns similar to their own” and in doing so, “feel more in touch with the world” (p. 6). In her discussion on commonality, Herman (1992) describes the concept of universality as the “restoration of social bonds with the discovery that one is not alone” (p. 215). In this chapter she makes reference to the social context of a group and the shared experiences of being a survivor of trauma. As indicated in this study, the shared experience of a trauma history acted as a foundation for Universality among participants. Frable, Pratt, and Hoey’s study (as cited in Hogg & Tindale, 2001) found that in therapeutic groups, when participants experience their problems as shared by others, they respond more positively to a stressful situation. The development of a therapeutic alliance and group cohesion in the PTSR depended on a sense of safety and trust. Safety and trust from the PTSR helped participants to enter Leisure Connections with the perceived presence of cohesion.

The common experience of trauma and the therapeutic community of the PTSR provided a shared experience among group members, and therefore a foundation for the development of group cohesion. The presence of a therapeutic relationship and a sense of cohesion among group members and between the Recreation Therapist was initially fostered in the common ground of the therapeutic community of the PTSR program; through group members previous interactions with the RT in the PTSR (before entering Leisure Connections); and through group members’ shared experience of a trauma history.

Factors associated with the therapeutic community model of the PTSR act as a social context and provided a safe and supportive environment for rehearsing new behaviours among group members such as resolving conflict, challenging self and others

to engage in behaviour change, and making healthier choices in leisure. The context created in the PTSR likely differs from the individuals' homes and work places, and society in general. As suggested by Wright & Woo (2000), "[t]he PTSR offers structure that provides predictability [...] and involvement in all aspects of the community is strongly encouraged, and validation is an important aspect" (p. 36). The PTSR provided a safe structure where group engagement behaviours between participants, the RT and other program staff began to develop (Bloom, 1994; Caldwell, 2005; Herman, 1992; Wright & Woo, 2000). In addition, the PTSR acknowledges the importance of leisure in processes of healing and coping with stress and trauma. Other staff members may refer patients to Leisure Connections to meet their personal goals. Leisure Connections participants also have access to *Play Shop* where they can practice engagement in leisure, and in the broader PTSR leisure is acknowledged as another area of life in which trauma is re-enacted (Griffin, 2005).

Propositions

Proposition 1- Recreation Therapist will use a range of facilitation techniques that contribute to the experience of a therapeutic alliance and group cohesion

The first proposition developed for the study was that the Recreation Therapist would use a range of facilitation techniques in Leisure Connections. These techniques would contribute to the experience of a therapeutic alliance and impact group cohesion. The findings from this study supported the proposition. Factors such as the group leader interventions and the RT's actions were found to impact group members' experience of therapeutic alliance and group cohesion. For example, in the following themes, *Group Members' Experience of Therapeutic Alliance*, *Group Cohesion*, and as indicated in

Table 4, the relationship between facilitation techniques and group cohesion was indicated as the RT's use of a combination of group leader interventions and actions to facilitate Leisure Connections. This was described in the data from the participant interviews; drawing out was used most frequently with movement in the room and scans the room and makes eye contact to engage group members.

Proposition 2- Individual group members will experience characteristics of a therapeutic alliance between themselves and the Recreation Therapist

The second proposition suggested that individual group members would experience a therapeutic alliance through the presence of characteristics such as: trust, safety, empowerment, and validation. This proposition was supported by the findings in this study. For example, in *Group Members' Description of Therapeutic Alliance with RT* the relationship between facilitation techniques and therapeutic alliance was indicated in the data from the participant interviews; participants' described experiences of the RT exhibiting characteristics common to a collaborative and respectful therapeutic relationship (trust, validation, empathic attunement) during facilitation of Leisure Connections.

Proposition 3 - Group cohesion will be influenced by the presence and experience of a therapeutic alliance during group facilitation

The third proposition suggested that group members' experience of group cohesion would be influenced by their experience of a therapeutic alliance in group. This proposition was supported. The findings from this study indicated that group members experienced the presence of a therapeutic alliance between members and with the Recreation Therapist, and this influenced their experience of group cohesion. For

example, in *Interpretation of Group Therapy Alliance Scale (GTAS)* the relationship between therapeutic alliance and group cohesion was indicated by participants' responses to the GTAS, which suggested their experience of an interdependence between therapeutic alliance, group therapeutic alliance, and group cohesion, as a result of the RT's use of facilitation techniques; psycho-educational and experiential exercises in Leisure Connections.

Proposition 4 – The PTSR will contribute to group members' experience of a therapeutic alliance and group cohesion

The fourth proposition developed for the study was that the larger therapeutic community (PTSR) would impact and/or contribute to group members' experience of a therapeutic alliance and group cohesion in Leisure Connections. This proposition was supported by the findings from this study. Factors such as PTSR program patients and staff, and therapeutic factors associated with other program components contributed to group members' experiences of a therapeutic alliance and group cohesion in Leisure Connections.

Revised Conceptual Framework

The initial conceptual framework was developed to explain the concepts of facilitation techniques, therapeutic alliance, group cohesion, and therapeutic community, and to identify the presumed relationship between these concepts. The initial conceptual framework was revised to reflect the findings of this study (Figure 6). In comparing the findings of this study to the original framework, the RT used a range of facilitation techniques and actions to facilitate Leisure Connections. In addition, the therapeutic community of the PTSR program had a greater than anticipated impact on participants'

experience of a therapeutic alliance and group cohesion as they entered Leisure Connections; and Leisure Connections had an influence on the therapeutic community of the PTSR (e.g., peers from previous blocks of LC, RT as substitute in other groups, RT's attendance at community meetings).

The dotted circles in the conceptual framework represent the main dimensions of the propositions, or the "key factors" that are described by the researcher. The presumed interrelationships in the study are indicated by the use of two-way arrows. The use of dotted circles represents the overlap and presumed relationship between key components in this study. The dotted circles denote the indeterminable boundary existing between the propositions. The revised conceptual framework is shown in Figure 6.

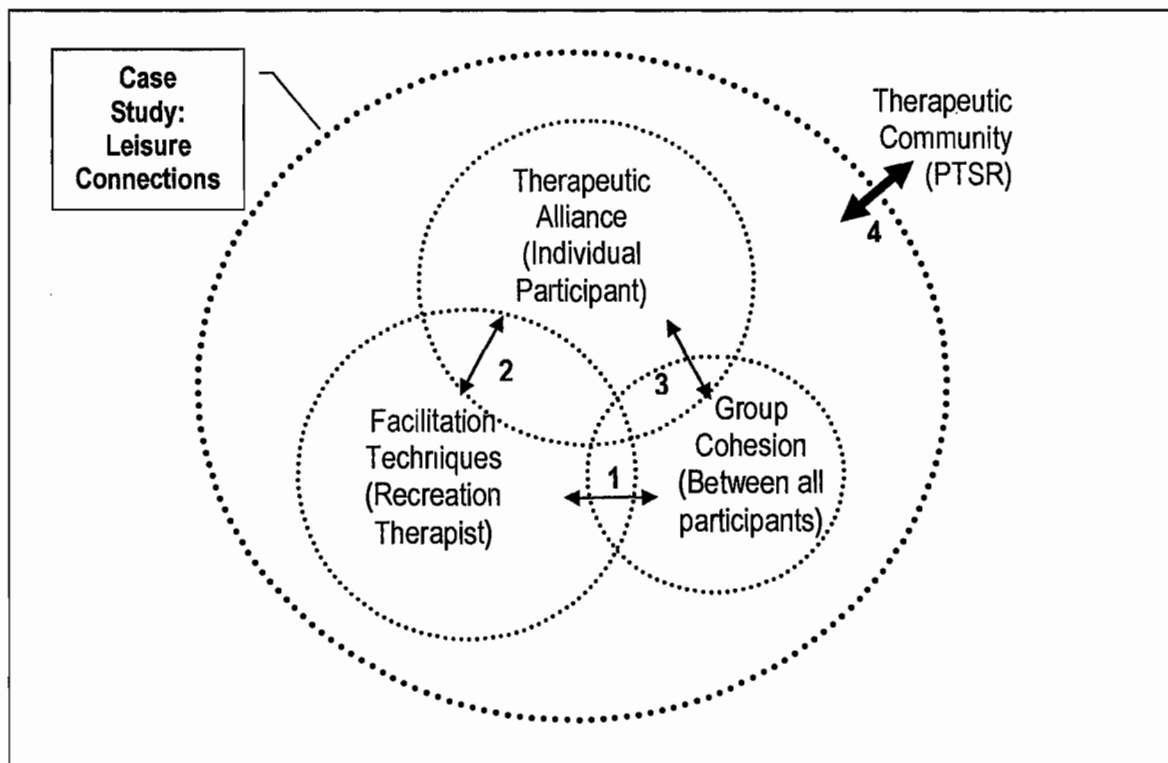


Figure 6. Revised conceptual framework.

Consequently, in the revised conceptual framework the location of the therapeutic community (PTSR) has been moved closer to proximity of the case, Leisure Connections, to indicate a larger impact on the participants' experience of group (Figure 6). Arrow 4 has been enlarged to indicate the greater influence of characteristics and interrelationship between the therapeutic community and Leisure Connections.

Significance of Findings

The importance of these findings are that facilitation techniques used with individuals who are survivors of trauma have not been documented using a leisure-based psycho-educational group format. Previous research with survivors of trauma has often focused on group treatment outcomes for combat veterans with PTSD (National Center for Post-Traumatic Stress Disorder, 2006; Veterans Affairs Canada, 2001). Other group treatment modalities used for survivors of trauma have included Eye Movement Desensitization and Reprocessing (EMDR) to focus on symptom relief and prolonged imaginal exposure therapy (PE), whereby repeated exposure to avoided situations is constructed (Rothbaum, Astin, & Marsteller, 2005; Taylor et al., 2003). Group treatment for survivors of trauma experiencing chronic PTSD has also included cognitive-behavioural therapy (CBT), which focuses on changing cognitive distortions; thoughts, feelings, and behaviours (van der Kolk, McFarlane & van der Hart, 1996; Korn, 2001; Ottawa Anxiety and Trauma Clinic, 2006; Santa Barbara Graduate Institute for Clinical Studies and Research, 2006). However, as reported by authors such as Meister and Pedlar (1992), Austin and Crawford (2001) and Caldwell (2005), there is a need for further trauma-related research that incorporates the leisure experiences of individuals who have experienced trauma. Not only does Leisure Connections focus on leisure but also uses a

combination of experiential and psycho-educational components creating a context to challenge participants' existing thoughts and new behaviours. These approaches along with the group leader interventions and actions, fostered the development of therapeutic alliance and group cohesion among the participants and the RT, and this was supported by the participants' experiences in program. These findings make an important contribution to the literature on both therapeutic recreation and group facilitation techniques used with survivors of trauma and therefore address gaps in the literature.

Recommendations for Developing a Practice Manual

The findings from this study will be used to promote the development of a practice manual for Leisure Connections group. The need for a practice manual has been indicated earlier in this study; currently there is no documentation of the facilitation techniques used in LC, nor is there a session-by-session manual for multidisciplinary team members to follow. In the event that the current RT is absent from Leisure Connections, a substitute RT would not have a standardized format or a set of treatment guidelines to follow for facilitating the group. As the findings suggest, the RT used a range of group leader interventions and actions to facilitate Leisure Connections. Consequently, the development of a practice manual, as Lichstein, Riedel, & Grieve (1994) suggest, will distinguish, "between the treatment that was intended to be delivered and the actual treatment delivered" (p. 1). This concept is consistent with establishing treatment integrity. Understanding how the facilitation was experienced by survivors of trauma in a leisure-based psycho-educational group addresses a need for documenting the group leader interventions used in Leisure Connections and the development of a practice manual.

Strengths and Limitations of the Study

The primary focus of this research was to describe the facilitation techniques used by a Recreation Therapist with survivors of trauma and describe how the facilitation was experienced by the participants. Using a qualitative methodology allowed for in-depth and thick descriptions in the words of the RT and the participants, to describe the facilitation techniques used and the experiences of facilitation in Leisure Connections (Patton, 2002). A qualitative case study was the approach used in this study. This approach to research explores a phenomenon and addresses how or why questions. In this study, the group, Leisure Connections was the defined unit of analysis (Creswell, 1994; Yin, 1994; 2003). Through the current study, the verbatim quotes of the Recreation Therapist and the participants described their experience of Leisure Connections, with little manipulation or control by the researcher. The findings indicated in this study, therefore attempt to remain true to the experiences shared during the interview process.

The criteria associated with trustworthiness provide a framework for evaluating the strengths and limitations of this study. The criteria that contribute to judgments of the trustworthiness and the techniques used in the current study to ensure trustworthiness are outlined below.

Methodological limitations and threats to trustworthiness of this study included the quality of data collected during direct observations. This limitation may be accounted for within the framework of the larger study; multiple data collections by multiple researchers for corroboration.

As described in the section, Strategies to Promote Rigor and Trustworthiness of Research, Patton (2002) suggests that credibility, transferability, dependability, and

confirmability are criteria that together promote trustworthiness of the findings.

Credibility is concerned with providing quality research that has believable analysis;

judgments of quality research will lead to perceptions of credibility (Patton, 2002).

Similarly, to increase judgments of quality, Lincoln & Guba (1985) propose techniques including activities in the field to increase credibility (prolonged engagement, persistent observation and triangulation), peer debriefing, negative case analysis, and member checks.

Limitations of this research include only two recruitment days; therefore it was difficult for this researcher to establish a relationship with possible research participants. There was no opportunity to video-tape LC sessions; therefore it was difficult to capture all possible interactions and RT facilitation during the field observation. Leisure Connections had a small group size; there were only 4 participant interviews out of six possible research participants. In this study, only one data collection phase occurred over three LC sessions. This is a brief period in which to observe the RT's facilitation of Leisure Connections, capture group interactions and dynamics among participants and the RT. Therefore, the concept of prolonged engagement to build trust among research participants and learn the culture of the research site did not occur (Lincoln & Guba, 1985). Participants' description of experiencing a sense of therapeutic alliance and group cohesion was influenced by other factors, including the therapeutic community of the PTSR (established alliance/relationships between group members and Recreation Therapist) prior to entering LC; the shared experience of trauma impacted participants' perception of group cohesion.

More sessions over time would add to the credibility of the research. Findings limit the ability to determine the full impact of the experiential exercises and facilitation techniques in the short period of time (three sessions instead of four; only collected data for one block of LC). Therefore, complete future research over more than one block of Leisure Connections.

Based on this researcher's availability, there was a time lapse between the completion of data collection and data analysis. To overcome this, all interviews were transcribed verbatim and reviewed as soon as possible after data collection. A further limitation of this study and the larger research project; one that is crucial for establishing credibility, is that member checks with participants were not possible. This is a limitation imposed by policies of the clinical facility where the study was conducted.

Recommendations for Future Research

The following suggestions arose from this study in consideration for future research. First, participants of the current study described the significance of a common or shared history of trauma and the importance of supportive and trusting relationships. It is recommended that a study be conducted with a similar in-patient treatment facility in order to learn about the transferability of these findings.

Second, continue to employ qualitative methods and incorporate the use of video-taping during observations. The rich descriptions of the data gathered through the observations and interviews demonstrates the relevance of qualitative methods when examining a specific experience and context; therapeutic facilitation in a group context.

Third, future studies should include an in-depth investigation of the facilitation techniques in Leisure Connections with other Recreation Therapists and with a larger population of survivors of trauma over a greater period of time.

Further suggestions for future research include a follow-up study with group members to see if they are incorporating healthy leisure practice into their lives; to see if participants have incorporated the experiential learning from Leisure Connections into their “real world” lives. Considering that some participants in the PTSR have only started their healing from trauma while some have had previous admissions/longer therapy interventions; future research could include a comparative study of responses with individuals who have not experienced trauma, to see if there are differences in their experience of facilitation.

Conclusions

The purpose of this case study was to describe the Recreation Therapist’s facilitation techniques used in Leisure Connections, a leisure-based psycho-educational group, and explore how this facilitation was experienced by the participants. The results of this study indicate that the RT used a range of facilitation techniques, including ten specific group leader interventions and numerous actions to facilitate LC.

As indicated in the findings and described by the participants’ experience of Leisure Connections, the facilitation of the experiential and psycho-educational components of Leisure Connections group helped to create a context that challenged participants’ existing thoughts and identified new healthier behaviours. The facilitation approach used by the RT in Leisure Connections also helped to foster the development of a therapeutic alliance and group cohesion among the participants and with the RT. This finding was

supported by the participants' described experiences in LC. The finding however, revealed that the therapeutic community had more of an impact in creating the essential foundation of a therapeutic alliance and group cohesion prior to patients entering Leisure Connections. The therapeutic community milieu of the PTSR and elements of safety were central to the formation of trusting interpersonal relationships and supports the participants' described experiences of facilitation. The participants identified how the social impact of the therapeutic community within the context of the PTSR and a shared history of trauma influenced their perceived presence of a therapeutic alliance and group cohesion in Leisure Connections.

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Appendix A- Participants' Interview Guide

Note. Interview questions (2, 3, 6, 7, 9, 11-16) are considered more relevant to the thesis research and are *italicized*. Additional questions added to the current study appear in upper case.

Introduction script for the post-session interview

Hello _____, it's great to see you again.

Before we get started I just want to remind you that I will continue to keep your responses confidential and that none of your comments will be attached to your name in any of my reports. With your permission I would like to audio record our interview to ensure that I can have an accurate record of your thoughts and to help me when I write up the results of the study. [If participant agrees] OK let's just test this to make sure it is working properly. [Do sound check]

This interview has been designed to gather your thoughts about your experiences in Leisure Connections and about how your understanding of leisure has changed. As we go through the interview, if I ask a question that you don't want to answer, or if you start feeling uncomfortable please let me know and we can move on to another question, or pause the interview if we need to. Did you have any questions for me before we get started?

Great! Let's get started.

1. **When you think about your time in the program before you started LC, what did you hope to gain from LC?**
2. ***When you remember your experiences in LC (provide cue card of activities), what are the main things that stand out for you?***
3. **Thinking about other groups in the program (assessment week, play zone, etc.), what does LC add that is different?**

How have other parts of the program helped you to understand leisure?

This next set of questions focuses on how LC has enhanced your understanding of leisure in your life.

4. **Before you came to the PTSR, what would your recreation and leisure in a typical week have looked like?**
5. **Before LC, what was your understanding of what leisure is?**
6. ***As a result of your experiences in LC how has your understanding of leisure changed?***

7. Was there a specific aspect of the group that helped you to make this shift?

I) WHAT GOALS DID YOU HAVE FOR LC GROUP?

II) WHAT DID YOU HOPE TO TAKE AWAY (LEARN) FROM GROUP?

III) DO YOU FEEL THAT THE OTHER GROUP MEMBERS HAD SIMILAR/SAME GOALS?

IV) HOW DID THE GROUP LEADER KNOW WHAT YOUR GOALS WERE?

8. This next set of questions explores your responses on the Leisure and Recreation Involvement scales that we did in Leisure Connections.

a. On the LRI your score at the beginning was ___ and at the end of Leisure connections it was ___, has the meaning of your leisure and recreation activities changed for you?

b. On the LRI your score at the beginning was ___ and at the end of Leisure connections it was ___, how has the pleasure you derive from your leisure and recreation activities changed for you?

Are you thinking about this differently? Are you feeling different when you are engaged in leisure?

How has your sense of fun or enjoyment changed?

How has LC influenced your understanding of self-nurturing? c. - Was there a specific experience in LC where you remember this happening?

c. On the LRI your score at the beginning was ___ and at the end of Leisure connections it was ___, how has your interest in leisure and recreation activities changed for you?

d. On the LRI your score at the beginning was ___ and at the end of Leisure connections it was ___, how has the importance of leisure and recreation changed for you?

e. On the LRI your score at the beginning was ___ and at the end of Leisure connections it was ___, has there been a change in the intensity that you feel when you engage in leisure and recreation activities?

f. On the LRI your score at the beginning was ___ and at the end of Leisure connections it was ___, has there been a change in how central your leisure and recreation activities are to your life?

9. When you think about your experiences in LC, has your understanding of yourself changed? Do you think about yourself differently as a result of Leisure Connections?

Was there a specific aspect of this group that helped you to make this shift?

I) WHAT SPECIFIC THINGS DID THE RT DO THAT WAS HELPFUL IN GROUP?

II) WHAT DID THE RT DO THAT WAS HELPFUL TO OTHER GROUP MEMBERS?

10. How did LC help you to understand the choices you make during your free time?

11. How did LC impact your understanding of yourself in relation to other people?

What did you learn about how you connect with others?

What did you learn about how you communicate?

What did you learn about how you trust others?

I) IN GROUP, HOW DID THE RT SHOW UNDERSTANDING TO GROUP MEMBERS?

II) HOW DID THE RT ENCOURAGE GROUP MEMBERS TO PARTICIPATE?

III) HOW DID THE RT ENCOURAGE GROUP MEMBERS TO COMMUNICATE?

12. *Thinking about the group of people you participated in LC with, how did the group affect your healing journey?*

How did it feel to be part of the group?

I) HOW DID OTHER GROUP MEMBERS HELP YOU?

II) WHAT SPECIFIC THINGS DID THE RT DO TO HELP YOU (IN GROUP)?

13. *When you were in Leisure Connections did it feel like you were individuals or a group?*

Did that change over time?

I) WHAT DID OTHER GROUP MEMBERS DO TO HELP YOU FEEL INCLUDED IN GROUP?

II) HOW TRUSTING OF OTHER GROUP MEMBERS WERE YOU?

III) WHAT DID THE RT DO TO HELP YOU FEEL INCLUDED IN GROUP?

14. *If you were to make recommendations about LC, what should we keep about LC? What should we change?*

15. *As your group facilitator, what does THE RT do well?*

I) HOW DID YOU KNOW THAT THE GROUP LEADER UNDERSTOOD YOUR NEEDS IN GROUP?

II) WHAT DID THE RT DO TO SHOW THIS?

III) WHAT DID OTHER GROUP MEMBERS SAY OR DO TO SHOW THAT THEY ACCEPTED THE RT AS THE LEADER?

16. *What areas could THE RT improve?*

I) WHAT DID THE GROUP LEADER DO THAT SHOWED SHE HAD THE SKILLS AND ABILITY TO HELP THIS GROUP?

17. *Anything else about your experience that you would like to add?*

Closing script for the interview

Thank you for participating in the interview. Do you have any questions for me? Any concerns about the interview that we just did?

Appendix B- Group Therapy Alliance Scale

The first two letters in your first name (e.g., JO if your first name is John): _____

INSTRUCTIONS

The following statements refer to your feelings and thoughts about the group leader (THE RT) and the benefit of the group (in this case, the group refers to the people in Leisure Connections).

Each statement is followed by a five-point scale. Considering how you are feeling at the present time, please rate the extent to which you agree or disagree with each statement.

If you "strongly agree" with the statement, circle number 5. If you "strongly disagree" with the statement, circle number 1. Use the numbers in-between to describe variations between the extremes.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
5	4	3	2	1

Please work quickly. We are interested in your first impressions. Your ratings are confidential. They will not be shown to the group leaders or other group members and will only be used for research purposes. Although some of the statements appear to be similar or identical, each statement is different.

Thinking about the group leader (THE RT) and this group (in Leisure Connections) please respond to the following statements. PLEASE BE SURE TO RATE EACH STATEMENT.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1. The group leader cares about me as a person.	5	4	3	2	1
2. I trust the group leader.	5	4	3	2	1
3. The group leader lacks the skills and ability to help this group.	5	4	3	2	1
4. The other clients in the group are helping me.	5	4	3	2	1
5. The other clients in this group feel accepted by the group leader.	5	4	3	2	1
6. The group leader does not understand this group.	5	4	3	2	1
7. The group leader understands what I need from this group.	5	4	3	2	1
8. Some of the other members are not in agreement with the group leader about the goals for this	5	4	3	2	1
9. Some of the other clients in the group do not understand me.	5	4	3	2	1
10: The other group members care about the group leader as a person.	5	4	3	2	1

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
11. The group leader does not understand what this group wants to accomplish.	5	4	3	2	1
12. The group members approve of the way that the group leader manages the group.	5	4	3	2	1
13. The group leader does not understand me.	5	4	3	2	1
14. Some of the other clients in the group are helping me.	5	4	3	2	1
15. The group leader is helping this group.	5	4	3	2	1
16. I am not satisfied with this group.	5	4	3	2	1
17. The group leader understands what all of the members want to get out of this group.	5	4	3	2	1
18. I do not feel accepted by the group leader.	5	4	3	2	1
19. The other clients and I are in agreement with each other about the goals of the group.	5	4	3	2	1
20. The group leader and I are in agreement about how the group is being conducted.	5	4	3	2	1
21. The group leader is not helping me.	5	4	3	2	1
22. The group leader does not care about some of the other members of this group.	5	4	3	2	1
23. Some of the other group members and I do not understand each others' goals in this group.	5	4	3	2	1
24. The group leader is not helping some of the other members of this group.	5	4	3	2	1
25. I trust all the other clients in this group.	5	4	3	2	1
26. The group leader has the skills and ability to help all of the members of this group.	5	4	3	2	1
27. Some of the members of this group distrust the group leader.	5	4	3	2	1
28. The group leader cares about this group.	5	4	3	2	1
29. The group leader does not understand some of the members of this group.	5	4	3	2	1
30. The group leader does not appreciate how important my relationships with some of the members of this group are to me.	5	4	3	2	1

Appendix C- Leisure and Recreation Involvement

Research has identified six different elements that describe your involvement in leisure and recreational activities. The purpose of the **Assessment of Leisure and Recreation Involvement** is to help identify how important (or not important) each of these six elements is to you. By answering these statements you can better grasp why you might want to engage in leisure and recreation activities. There is no "correct" score. This scale tells you about how you feel about your free time and leisure. Read each statement then circle the number to the right of the statement that best describes you.

	1 Strongly Disagree	2 Disagree	3 In- Between	4 Agree	5 Strongly Agree
1. I reserve sufficient time to engage in my favorite leisure activities.	1	2	3	4	5
2. I continue to do the leisure activities of my choice, even when I am busy.	1	2	3	4	5
3. There is a focus for my leisure choices.	1	2	3	4	5
4. My leisure activities are parts of my lifestyle.	1	2	3	4	5
5. My favorite leisure activities give me pleasure.	1	2	3	4	5
6. After completing my leisure activities, I usually feel satisfied and full.	1	2	3	4	5
7. I identify with the leisure activities I favor.	1	2	3	4	5
8. I take pride in the leisure activities in which I engage.	1	2	3	4	5
9. I usually want to know more details about the leisure activities that interest me.	1	2	3	4	5
10. Engaging in my favorite leisure activities expresses my wishes.	1	2	3	4	5
11. Engagement in my favorite leisure activities is worthwhile.	1	2	3	4	5
12. I practice the skills required to improve my leisure performances, if needed.	1	2	3	4	5
13. The leisure activities I do occupy my feelings.	1	2	3	4	5
14. My favorite leisure activities help me to discover many things about myself.	1	2	3	4	5
15. My choices of leisure activities give a sense of inner freedom for me to do what I desire.	1	2	3	4	5
16. I expect something good to come out of my participation in my favorite leisure activities.	1	2	3	4	5
17. I feel that I am responsible about choices made to participate in leisure activities.	1	2	3	4	5
18. I am willing to devote mental and/or physical effort to master my preferred leisure activities.	1	2	3	4	5
19. I like to do my leisure activities well, even when they require a great deal of time and effort.	1	2	3	4	5
20. For my preferred leisure activities, I am willing to invest my money, time, and energy.	1	2	3	4	5
21. Without engaging in my favorite leisure activities, life has no flavor.	1	2	3	4	5
22. I express myself best when I am doing my favorite leisure activities.	1	2	3	4	5
23. My leisure activities give me a sense of value in my life.	1	2	3	4	5
24. I do not know what to do without my leisure activities.	1	2	3	4	5

Appendix D- Combined Letter of Introduction and Informed Consent Form

Title of Study: Evaluating Leisure Connections

[printed on letterhead of Brock University and Homewood Health Centre]

Principal Researcher and Interviewer:
Dr. Sue Arai, Department of Community Health Sciences
March 2007/April 2007

About the program evaluation

Carrie Greig and Dr. Sue Arai from the Department of Community Health Sciences at Brock University are working with Janet Griffin, Recreation Therapist at Homewood, to evaluate the Leisure Connections group. The program evaluation will focus on understanding the impact of Leisure Connections on your awareness of leisure, knowledge of the benefits of leisure as a healthy coping resource, awareness of self and self-nurturing practices, and how Leisure Connections has contributed to your healing process. The research questions that guide this study are:

1. How does Leisure Connections facilitate client's knowledge and awareness of leisure in relation to experiences of healing from trauma?
2. What role does the practitioner play in the client's healing journey?
3. How does the Leisure Connections group assist participants on their healing journey?

Why are we doing the program evaluation?

Your involvement is greatly appreciated and will help to further our understanding about the ways Leisure Connections supports people in their healing journey. Your input will help us to make improvements to Leisure Connections and inform others about providing supports to people healing from trauma.

- *I understand that the purpose of this investigation is for program improvement; specifically, to understand the effects that Leisure Connections has on increasing participants' awareness and knowledge of leisure and how Leisure Connections contributes to the healing process.*

What will I be asked to do?

Carrie will be conducting an observation of Leisure Connections (4 sessions over 2 weeks). In addition, you will be asked to participate in an interview after participating in the Leisure Connections group. Each interview is expected to last approximately forty-five minutes. Some questions you might be asked include: What did you hope to gain from your participation in Leisure Connections? How has your participation in Leisure Connections affected the way you spend your leisure time?

- *I understand that my participation in this study will involve:*
 - a) *participation in an interview that will last for approximately 45 minutes*
 - b) *observations made at each of the four Leisure Connections sessions*
 - c) *analysis of the reflection cards that I complete during the group process*
 - d) *two short questionnaires (two times).*

Are my rights being protected?

To minimize any risks to you, every step has been taken to protect your identity. We are taking great care to ensure that information provided by you will remain confidential. Your real name will not be attached to observation notes, comments or issues raised within discussions, project reports or presentations generated from this study. To ensure that the program evaluation will not affect your experience in Leisure Connections the program facilitator, Janet Griffin will not know whether you are participating in the study. This information will be limited to you and Carrie and Sue from Brock University.

- *I understand that:*

- *my participation in the study will bring only minimal risks or harms.*
- *participation in this study is voluntary. I may withdraw from the study at any time and for any reason without penalty. I understand that if I choose to withdraw from the study my participation in Leisure Connections will not be affected.*
- *I may ask Carrie questions at any point during the research process.*
- *there is no obligation for me to answer any questions I feel are invasive, offensive or inappropriate.*
- *there will be no payment for my participation.*
- *the interviews I participate in will be audio taped to ensure accuracy and will be destroyed upon completion of the study.*
- *my interview data is not anonymous (since my identity is known by Carrie) but all personal information will be kept strictly confidential. This means that:*
 - *all information will be coded so that my name will not be associated with specific responses.*
 - *only Carrie and Sue will have access to the original audio tapes and observation notes.*
 - *to protect my identity, information seen by Janet Griffin (Recreation Therapist) will be labeled with my code name.*
 - *all original audio files and information containing my true identity will be stored in a password protected computer system.*
 - *the notebook in which observations will be recorded will be kept in Carrie's possession at all times when at Homewood and my code name (not my true identity) will be used in these observation notes. I understand that these original observation notes will be destroyed at the end of the study.*
 - *I understand that the master list linking my name with my code name will be destroyed at the end of the study.*
- *confidentiality will be maintained unless disclosure of information is required by law. For example, in instances where the intent to harm self or others is disclosed to the researcher.*

If I agree to participate now, can I withdraw from the study later?

You may withdraw from the study at any stage in the process by informing the researcher (Carrie) or your nurse.

- *I understand that I may withdraw from the study at any point. To do so, I will contact either my nurse or the researcher or Carrie.*

How will I find out about the results of the study?

A written summary of the findings will be made available to you either by mail or by contacting Janet at the Homewood Health Centre. Additional reports may appear in academic journals and conference presentations; however, the specific identity of the participants in the study will not be disclosed.

- *I understand that the results of this study will be distributed in academic journal articles and conference presentations and a summary of the results will be made available to Homewood and participants in the study.*

Who should I contact if I have questions or concerns?

If you have any questions about the interviews or the study in general, please contact us at Brock University:

- Carrie Greig, Department of Community Health Sciences (905-688-5550 extension 3882; by e-mail at carrie.greig@brocku.ca)
- Dr. Sue Arai, Department of Community Health Sciences (905-688-5550 extension 4783; by e-mail at sarai@brocku.ca)
- Concerns about your involvement in the study may also be directed to Research Ethics Officer of the Brock Research Ethics Board at 905-688-5550, extension 3035.

Alternatively, if you wish to contact someone at Homewood:

- You may direct general questions about the research to Janet Griffin, Recreation Therapist (519-824-1010 extension 2509; or e-mail at GrifJane@homewood.org).
- Questions about ethics (e.g., confidentiality, informed consent, your rights etc.) to Dr. Steve Abdool, Bioethicist and Director (519-824-1010 extension 2118; e-mail abdostev@homewood.org).

Has this research been approved by an ethics committee?

This study has been reviewed and received ethics clearance by the Research Ethics Board at Brock University (file # 05-349) and the ethics committee at Homewood Health Centre.

To be completed by you, the participant

Name: (please print) _____

- I have been given and have read the attached document provided to me by the researcher.
- By signing this letter/consent form, I am agreeing to the terms outlined in it and I acknowledge that I am participating freely and willingly and I am providing my consent.

How would you like to obtain the results of the study (please check one of the following):

- ☐ I would like to have a copy of the executive summary mailed to me.

Address _____

City/Province _____

To be completed by the researcher

- ☐ I have fully explained the procedures of this study to the participant.

Thank you for your help! Please take one copy of this form with you for further reference.

To be completed if you choose to withdraw from the study

If you wish to withdraw from the study, please indicate below your wishes regarding your data and further participation in Leisure Connections:

- ☐ I wish that specific observations of me not be taken but acknowledge that the researcher will continue to make general observations of the Leisure Connections group. I will allow data previously collected to be used in this study.
- ☐ I wish that specific observations of me not be taken but acknowledge that the researcher will continue to make general observations of the Leisure Connections group. I will not allow data previously collected to be used in this study.
- ☐ I wish to attend a different session of Leisure Connections (one that is not being evaluated). I will allow data previously collected to be used in this study.
- ☐ I wish to attend a different session of Leisure Connections (one that is not being evaluated). I

Appendix E- Letter of Appreciation

[printed on letterhead of Brock University and Homewood Health Centre]

April 2007

Dear _____

Thank you for your participation in the research project, "Evaluating Leisure Connections" and for taking the time to share your experiences with us. As you are aware, this research project was being conducted by [insert name of the researcher: Susan/Ashleigh/Carrie] of the Department of Community Health Sciences at Brock University in cooperation with Janet Griffin, Recreation Therapist at Homewood Health Centre. Your participation has enabled us to develop insight into how to make improvements to Leisure Connections. This will help us to ensure that participants are receiving the greatest benefit from the group.

Feedback about the results of the study will be available in March 2007, and will be mailed to you or can be picked up from the Homewood Health Center.

If you have any concerns, questions or further comments about this research project, please do not hesitate to contact Dr. Susan Arai in the Dept. of Community Health Sciences (905-688-5550 extension 4783; or e-mail sarai@brocku.ca). Concerns about your involvement in the study may also be directed to Research Ethics Officer of the Brock Research Ethics Board at 905-688-5550, extension 3035 (refer to file #05-349). Alternatively, at Homewood, you may direct general questions about the research to Janet Griffin, Recreation Therapist (519-824-1010 extension 2509; or e-mail at GrifJane@homewood.org) and questions about ethics (e.g., confidentiality, informed consent, your rights etc.) to Dr. Steve Abdool, Bioethicist and Director (519-824-1010 extension 2118; e-mail abdostev@homewood.org).

Thank you again for your participation!

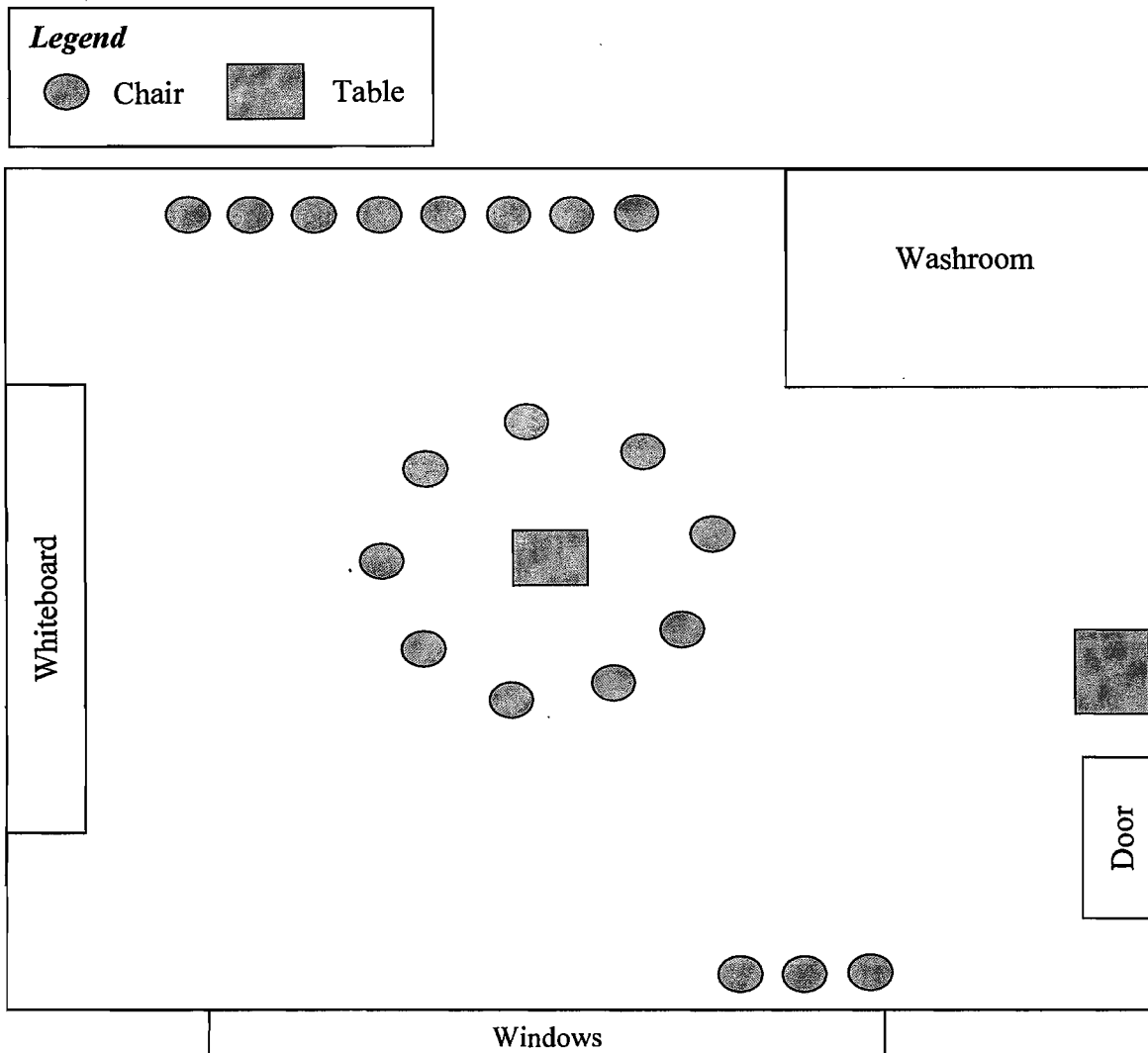
Sincerely,

Susan Arai, Ph.D.
Associate Professor, Faculty of Applied Health Sciences

Ashleigh Miatello/Carrie Greig
M.A. candidate, Faculty of Applied Health Sciences

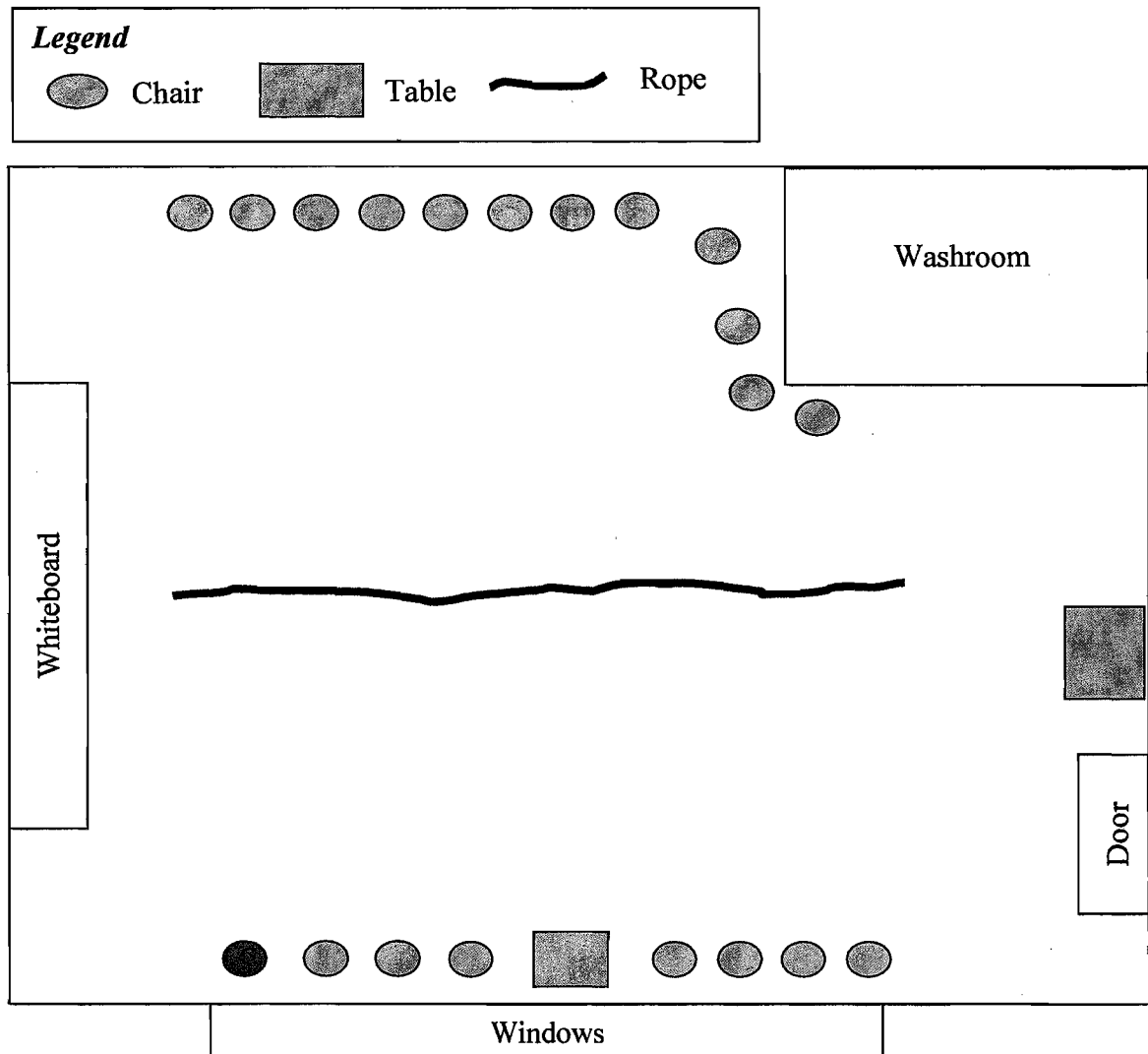
Appendix F- Observation Protocol

Leisure Connections Group Room

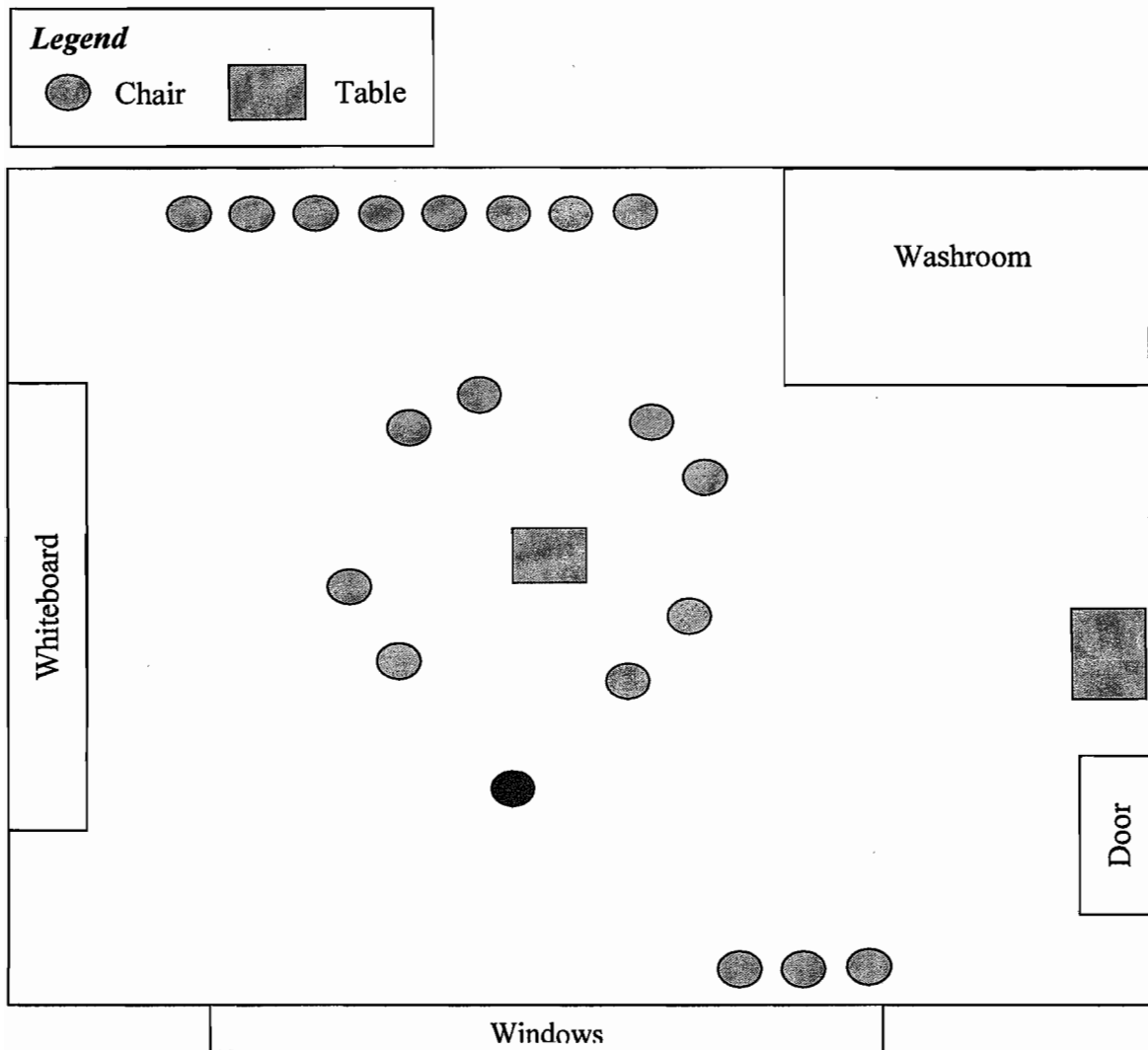


Short Form Coding (during observation)

- RT=** Recreation Therapist.
- TO=** Tony (example, participants in the research will be identified with first two letters of first name. Pseudonyms will be applied following the observation.)
- C1=** Client 1 (non-participant in research).
- C2=** Client 2 (non-participant in research).
- WO=** Window open.
- WC=** Window closed.
- LO=** Lights on full.
- LD=** Lights dim.

Tug-of-War Experiential Exercise***Short Form Coding (during observation)***

- RT=** Recreation Therapist.
TO= Tony (example, participants identified with first two letters of first name)
C1= Client 1 (non-participant in research).
C2= Client 2 (non-participant in research).
WO= Window open.
WC= Window closed.
LO= Lights on full.
LD= Lights dim.
LB= Low, back stance.
FO= Stance mainly on front foot (to off balance)
SW= Sideway stance

Pat-A-Cake Experiential Exercise***Short Form Coding (during observation)***

- RT= Recreation Therapist.
 R= Researcher
 TO= Tony (example, participants in the research will be identified with first two letters of first name. Pseudonyms will be applied following the observation.)
 C1= Client 1 (non-participant in research).
 C2= Client 2 (non-participant in research).
 WO= Window open.
 WC= Window closed.
 LO= Lights on full.
 LD= Lights dim.

Appendix G- 10 Group Leader Interventions

1) Protecting group members/promoting safety includes: protecting, blocking, and supporting.

Protecting – leader intervenes to protect member from sharing too much; used to promote a feeling of safety (initial stage of group).

Blocking – specific protection to block member from inappropriate probing, gossip, rambling; intervening with directness for interest of group.

Supporting – an intervention to reassure and encourage members; excessive supporting may foster dependency on the leader.

2) Energizing/involving group members includes: drawing out, modeling, linking, processing, interpreting, self-disclosing, and feedback.

Drawing out – group leader invites participation or comments to one or more member.

Modeling – leader encourages respect, feedback, and demonstrates skills, attitudes that are hoped to engender in members.

Linking – leader intervention encourages group interaction; connects what one member has said with the concerns of other members to promote group cohesion.

Processing – group leader and members reflect on meaning; thoughts, feelings, and actions; opportunities for members to gain insight about how others perceive them.

Interpreting – group leader assists members by providing interpretation; displays understanding of motivations, patterns of behaviour.

Self-Disclosing – group leader disclosure of here and now reactions to group members.

Feedback – group leader shares own observations or reactions regarding the behavior, thoughts, and feelings of another.

Note. Adapted from Morran, Stockton, & Whittingham (2005, p. 93-100)

Appendix H- Recreation Therapist Interview Guide

Introduction script for the post-session interview with the Recreation Therapist

Hello Janet, thank you for meeting with me.

I want to remind you that I will keep your responses confidential. With your permission I would like to audio record our interview to ensure that I can have an accurate record of your thoughts and to help me when I write up the results of the study. [as Recreation Therapist agrees] begin interview [do sound check].

This interview has been designed to ask you about your experience of facilitating Leisure Connections. As we go through the interview, if I ask a question that you don't understand or wish to respond to, please let me know and I will clarify, or we can move on to another question, or pause the interview if we need to. Did you have any questions for me before we get started?

1. How do you prepare for Leisure Connections group prior to each session?
2. What specific facilitation techniques are you [aware of] using in group? Give examples.
3. How do group reactions influence your decision to change or continue with an intervention during group? Give an example or explain more.
4. Why is it important that group members' experience "in-the-moment" awareness during Leisure Connections?
5. In your experience of this block of Leisure Connections, what were the specific group interventions you used?
6. How important are leader behaviours [acknowledging, empathy] in facilitating a group? Give example.
7. Does your awareness of the [current] group experience influence your facilitation of the next LC session? Explain.
8. How do you respond to group members experiencing noticeable affective changes?
9. Do you use different facilitation techniques during the education component than the experiential component?

Appendix I- Recreation Therapist Reflection Questions

Introduction script for the post-session (1-3) Reflection Questions with the Recreation Therapist

Hello Janet, thank you for meeting with me.

I want to remind you that I will keep your responses confidential. With your permission I would like to audio record your verbal responses to the reflection questions to ensure that I can have an accurate record of your thoughts and to help me when I write up the results of the study. [as Recreation Therapist agrees] begin interview [do sound check].

Your responses, recorded as an interview, have been designed to ask you about your experience of facilitating Leisure Connections. As we go through the interview, if I ask a question that you don't understand or wish to respond to, please let me know and I will clarify, or we can move on to another question, or pause the interview if we need to. Did you have any questions for me before we get started?

1. What stood out in my awareness about the experience of group?
 - 1b. How did that awareness influence my decisions, feelings, actions during group?
2. What could I have done differently or kept the same given my awareness?
3. What stood out in my awareness about myself and the group experience?
 - 3b. How did that awareness influence my decisions, feelings, actions during group?
4. What have I learned about myself?

Appendix J- Structured Memo for Observations

Site: _____

Observation Date: _____

Today's Date: _____

Researcher: _____

1. What was happening as group members entered the room?
2. What was occurring as Janet introduced Leisure Connections group?
3. What did I observe about group members when Janet asked for participation to the education component (questions)?
4. What did I notice about group members during the experiential exercises?
5. What did I notice about Janet during the experiential exercises?
6. What happened during debriefing of the experiential exercise?
7. What did I observe related to therapeutic alliance/group cohesion?
8. What did I notice during the completion of Reflection Cards?

Appendix J- Structured Memo for Observations - Case study questions

1. What **actions** are being carried out by the Recreation Therapist? (in each LC component)

1b. What **group leader interventions** are used by the Recreation Therapist?

2. What is the **nature of the interaction** between the participants and the Recreation Therapist?

3. What are the **noticeable reactions and changes** in the participants as the session progresses? (each session).

Appendix K- Detailed Description of Leisure Connections

Leisure Connections Session #1

The first session started a few minutes late. The Recreation Therapist (RT) was writing on the white board as group members entered the room and sat in chairs. All chairs were arranged in a large circle and a handout had been placed on each chair. There was talking and laughter among the group members. A request was made by one group member to close the window. The RT responded immediately, stating that the comfort level in the room was important, so comments about the lights and/or temperature were good to make. The lights were dimmed in half of the room. The last to arrive, the researcher entered the room, closed the door, and sat within the group circle, as requested by the RT. Seven of the eight registered patients were present in group. Six had agreed to participate in the study. The RT sat in the circle with the group and welcomed group members. She acknowledged my presence and my involvement as a researcher from Brock University. The RT stated that she was not aware of which group members were participating in the research project. She emphasized that her role was to facilitate Leisure Connections. The RT explained that there were two handouts for Leisure Connections session #1, and that one of them had been distributed, so group members did not need to take notes. She asked group members if they were ready to begin for today. Some of the group members responded verbally in acknowledgement.

The introduction to Leisure Connections group continued and the RT informed group members about what to expect. She explained the group format, and informed participants that Leisure Connections is usually four sessions, but due to the approaching statutory holiday; this block would have three sessions. The RT added that the first two

sessions contain more educational components of leisure. She shared her insight with the group members about facilitating Leisure Connections over the past nine years, adding that she has found that most people learn by doing. The RT briefly described that group members would be using Reflection Cards at the end of each session to identify what may have changed for them. As she introduced Leisure Connections most group members appeared attentive.

The psycho-education component of Leisure Connections began as the RT moved to the white board and asked group members to consider five statements that she read aloud. The statements written on the board included:

- My favourite activity in childhood or now is ...
- I don't do it much but I enjoy ...
- If I didn't have to do it perfectly, I would ...
- If I wasn't too selfish, I would ...
- If money was no object, I would ...

A group discussion was initiated as the RT asked group members to choose one or more of the statements and share a response. She was clear to emphasize to group members to share only if they felt comfortable. The discussion continued with active group participation from all but one group member. The RT included the use of prompts to encourage participation from group members; "are there any other responses from the group, any others up there that people feel comfortable to share?" As this part of the group concluded, she explained that this exercise was a way to help group members make connections with other things about themselves; about who they are, about honouring the whole self, and that they are not just the trauma they had experienced.

The next psycho-educational component was introduced as the RT moved to the white board and wrote: **1) Activity**. A question is posed to group members, "What is it

that stops you from doing what you want to do?” This question prompted group members to respond. The RT draws out from group members as another question was posed, “How many of you would show up to floor hockey as a leisure activity?” Affirmative responses to this question were from male group members only. This part of the session was explained to group members as how an activity choice can be connected to trauma; of making connections to the choices made in leisure; about being aware of the emotional connections and unhealthy choices.

The next topic of discussion was explained by the RT as the concept of enjoyment in leisure. She then asked the group, “What is leisure?” As she asked this question, the RT moved to the white board and wrote: **2) State of Mind- Enjoyment**. All group members are focused and looking at the board. The RT returned to her seat and stated that when choices in leisure activity are made to “not rock the boat” they are often resented. The RT noted that these types of leisure choices are connected back to survival, and she described the connection to experiences of hyper-vigilance and hyper-alertness. The RT explained that if this is the case, then it would be difficult for the person to have fun or experience enjoyment during an activity. Some group members responded by nodding, as if to acknowledge the statements made by the RT. She encouraged further participation by addressing the whole group, scanning the group and making eye contact with each person as she posed another question, “Do you have a sense of what it’s like if people get to know you?” Quickly, she asked another question to promote further discussion. The RT continued to ask questions and included the group by turning her head as she spoke and looking around the circle; making eye contact. The discussion continued; tying together the concepts of hyper-vigilance, state of mind, and enjoyment in leisure. The

Recreation Therapist then leaned toward the group members in her chair and posed a question to them about coping with trauma through the use of drugs and alcohol. She explained this part of the discussion as a way to make a connection to traumatic reenactments. The RT commented that the behavior of using drugs and alcohol to cope with trauma is actually keeping oneself stuck in their trauma. She then asked the group if they were able to make the connection between these concepts. There was an affirmative response from most group members. The Recreation Therapist then moved to the white board and wrote: **3) Choice**. The RT then stated to the group that as children we did not have choices, but as adults we do. The RT spoke about choices made based on two types of motivation, intrinsic and extrinsic, as she wrote these headings on the board. Turning to the group, the RT then asked them to share words that indicate that an activity is externally motivated. As members of the group responded their statements were written on the white board (e.g., obligation, expectation, approval, avoidance, shame and guilt). The RT turned to the group and asked if anything else came to mind. She shifted the discussion to the concept of intrinsic motivation asking the group how they would feel if they did something because they wanted to do it for themselves. The RT wrote their responses on the board under the heading intrinsically (e.g., pride, feel good about myself, and connection). She then turned to the group and asked, "How many came here today thinking that this group about leisure might be useless?" As she said this she wrote: **4) Free Time** on the board. The RT did not have time to continue due to time constraints.

The RT closed the group by thanking the group for their participation. She asked group members to reflect on the group and to write on the reflection cards what stood out for them about themselves. A final statement was made by the RT to group members; that

if something came up, to take it to other groups to process. She handed out Reflection Cards and left the room. Group members moved in their chairs, some stretched, some moved to other spaces in the room. I handed out the Group Therapy Alliance Scale to group members and then collected them along with the Reflection Cards. The time was 2:30pm.

Leisure Connections Session #2 started late at 1:25pm. Six of the eight group members who had signed up for group were present for session #2. The two absent group members were research participants, four participants were present. The Recreation Therapist was seated as group members entered the room. The researcher sat within the circle. The lights were on in half of the room.

The RT started session #2 by asking if anyone remembered last week. She prompted the group by asking if others would like to share their awareness or feelings about last session. A short discussion continued. The RT began to segue to the next part of the session, and she again asked the group if they had any other thoughts, or awareness, or anything left over from last week. She then briefly recapped the last session and asked the group to sit facing a partner, emphasizing, "Find someone in this group who you feel safe with and pair up." There was shifting of chairs, laughter and conversation among group members as they moved into pairs. The researcher moved to sit just outside of the circle, seated slightly behind the paired dyads. The RT stood up and verbally acknowledged that some group members may be experiencing feelings associated with sitting in closer proximity to one another. She introduced the experiential exercise by stating, "I want you to notice, pay attention to that knee-jerk reaction; speak about whatever you notice." She emphasized again with a slower pace, "All I'm asking

you to do is pay attention to what you notice – there is no right or wrong. Pay attention to what it feels like sitting this close to someone.” The RT offered verbal permission for group members to take a deep breath. The group responded; making a gesture of breathing in and out.

The RT started the experiential component of the session; moving her hands in the air in the motion of “Pat-A-Cake” and asking the group to do the same with their partner. All group members responded by imitating her example. Some group members laughed. The RT suggested that they keep the pattern going and then asked them what they were noticing. The exercise continued for about one minute. The RT explained that the basic clap pattern was intended to represent traumatic reenactment.

Group members watched as the RT started the clap motion of the Pat-A-Cake exercise again and said, “The clap represents how you [group members] continue to create patterns in your life even when they hurt.” The RT stood and asked the group to begin the hand clap motion. Additional direction is given from the RT for one of the group members of each dyad to change the basic clap pattern. More direction is given for group members to make another change to the clap pattern. The exercise continued for two to three minutes. The RT then asked the group to stop and reform into a circle. The researcher rejoined the formation, but remained slightly outside of the perimeter. As the RT asked a series of questions about their experience of the exercise, all group members continued to actively participate in the discussion by responding or offering feedback to other group members. Group members described experiences such as the need for control, the concept of challenge, traumatic reenactments, and negative self-talk.

The Pat-A-Cake exercise was initiated again and the RT asked the group members to, “think about a pattern you are going to create and tell your partner this time.” The group moved into the same dyad pairs and continued for approximately two and a half minutes. The RT then asked the group members to start the exercise again, but this time, they were to show or tell their partner the changes they would make to the clap pattern. All group members continued for approximately one minute. The RT sat down and asked the group, “How did that feel?” Responses from group members included words related to experiencing a level of comfort, having control, making decisions and feelings of safety.

The RT explained that the Pat-A-Cake exercise is used to show the connection between healthier patterns of communication and decreased traumatic reenactments and healing. The RT noticed the time and closed the group; suggesting that group members’ journal and/or take left over feelings to other groups. The RT handed out Reflection Cards and pens and left the room. The time was 2:31pm.

Leisure Connections session #3 started on time. Seven of the eight group members; and five of the six research participants were in the room. Two participants had arrived late but the RT had announced that two group members would be late due to medical appointments. The Recreation Therapist was seated as group members entered the room. The researcher sat within the circle. The lights were dimmed in half of the room. Group members conversed among themselves about last session (Pat-A-Cake). The RT started session #3 by standing and then asking the group, “Does anyone remember last day? Anything left over?” There were two interruptions from late group members. The RT continued each time, stating that the group was carrying on with leftovers from

last session. The discussion continued. Then, the RT began to segue to the next part of the session.

The RT informed the group that the first part of the session would include use of the white board, and in the second part, they would move to the experiential exercise. The RT started the psycho-educational component by asking group members to consider a healthy choice they have made for themselves while in the PTSR program. She asked, "What did you get out of it?" The RT then asked the group, "How many of you went for a coffee with someone?" Group members started to respond. The RT moved to the white board and wrote their words on the board (e.g., nervous, validated, confident, had fun). She continued, "How many here went for coffee with someone?" Group members responded with feelings describing their experience (e.g., safe, laughter, comfortable, team, belonging, connection, shared). The RT prompted the group with another question, asking how they experienced other healthy choices and leisure pursuits. She added words to their list on the board (e.g., fun, proud, freedom, relaxed, independent, choices, and more self-esteem).

The exercise shifted as the RT moved away from the white board and closer to the group. She addressed the group with a question, "What could you see happening over time if, on a regular basis, you did more of the words on the board?" Responses from the group were added to the white board in a separate column from the previous list (e.g., healthy routine, living in the present, positive self-talk, healthier relationship, belonging, and healthier coping). The RT prompted group members for more responses. Then, she explained that the white board exercise was a way to help the group recognize the healthy choices and leisure pursuits that they are already involved in. The RT stated in a slow and

deliberate tone, "I didn't ask you how many people have a yacht, how many can scuba dive. I asked what you're already doing."

The experiential component of Leisure Connections session #3 started as the RT introduced the Bean Bag exercise. She asked the group to stand and form a large circle. The researcher moved to the outside wall and resumed sitting. All group members, including the RT began tossing one bean bag across the circle, with each person receiving and sending the bean bag to two different people. Gradually, more bean bags were added until there were approximately eight bean bags being tossed among the group. As the exercise continued, bean bags fell to the floor and group members picked them up. The bean bag toss lasted for about seven minutes, stopping when the RT asked group members to gather the bean bags and return them to her. To debrief the RT asked, "What do you notice now?" During the discussion, the RT asked the group to consider how much attention they pay to others' needs and wants in life versus their own. To conclude the RT made a statement about being present and the power of the present. The RT then returned the reflection cards from the previous two sessions to group members. Group members moved throughout the room to find space to complete their last reflection card. The RT then asked group members to share any observations about their returned reflection cards. She concluded the group with a general statement about beliefs; about being preoccupied with what others think of you, and holding on to what you believe. The time was 2:35pm.